PROVIDER-LEVEL MANUAL ADAPTATION:

PATTERNS, PREDICTORS, AND IMPACT ON CHILD OUTCOMES

A Thesis

by

LETICIA DUVIVIER OSTERBERG

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

May 2009

Major Subject: Psychology

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ABSTRACT

Provider-Level Manual Adaptation: Patterns, Predictors, and Impact on Child Outcomes.

(May 2009)

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Manualized, evidence-based treatments (EBTs) for children are being increasingly incorporated in community mental health clinics. Yet, providers hold concerns about the appropriateness of manuals for community populations, as suggested by the research of Jensen-Doss, Hawley, Lopez and Osterberg. Such concerns could lead them to adapt EBTs in the field, potentially diminishing or increasing their effectiveness. Therefore, it is striking how little is known about provider-level manual adaptation in community settings. The present study investigated the extent to which therapists mandated to use a manualized EBT adapt the treatment in the field, including patterns, predictors and outcomes of adaptation. A typology of provider-level manual adaptation was created to describe sessions double-dipped (i.e., repeated), skipped, or flipped (i.e., delivered in reverse order).

Patterns of manual adaptation used by a sample of 38 community therapists treating 288 depressed youths with Lewinsohn and colleagues' Adolescent Coping with Depression course (CWD-A) were described. Hierarchical Linear Modeling was used to identify which client and therapist characteristics predict manual adaptation, and whether adaptation is associated with greater improvement or worsening in youths' therapy outcomes.

Adaptation was widespread and largely unsystematic, with no significant client

predictors of repeats or flips. Sessions were skipped more often for youths belonging to families with higher income and youths with greater pre-treatment symptom severity, but less often for Hispanic and Asian youths relative to Caucasians. A significant portion of variability in adaptation was attributable to therapists, who showed habits in manual adaptation: therapists with more years of experience working at the clinics double-dipped sessions more often, and Hispanic therapists flipped sessions much less often than Caucasian therapists did. Finally, adaptation was significantly related with outcomes, such that double-dips were associated with worsened symptom severity, skips were associated with improved symptom severity, and flips were associated with worsened functioning.

Given that these data suggest manualized EBTs are likely to undergo vast adaptation in community settings, and that such adaptation is related to client outcomes, further research is necessary to better inform practitioners about when each type of manual adaptation may be appropriate. Practical implications for implementation efforts are discussed.

DEDICATION

This work is for the children at Northwest Children's Home, whom, having been given so little, found so much to share with me and with which to fill my heart. You have inspired me to arrive where I am today.

This work is also for the children and therapists in this study, whose journey has taught me so much. You inspire me to keep venturing into the unknown.

Finally, this work is for my loved ones. It is for my parents, my brother, and my aunts, Angela and Isabel – all of whom instilled my passion for life, learning, and awe for the human potential, and whose love and support I can always count on. And of course, it is for my husband - my partner in defying the odds - who has spent the last several years helping me grow and accomplish what I dream of doing. Thank you for helping make this possible.

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I thank my committee chair, Dr. Jensen-Doss, for sharing my enthusiasm for this project, for challenging me in ways that improve the quality of my work and help me grow, and for believing in me even during the most trying of times. Your support has meant so much. I thank also my committee members - Dr. Newman, for inspiring me to continually improve the conceptualization and methodology of my research, and Dr. Knight, for her guidance and support throughout this course of research.

TABLE OF CONTENTS

Page

ABSTRACT iii

DEDICATION v

ACKNOWLEDGEMENTS vi

TABLE OF CONTENTS vii

LIST OF TABLES ix

INTRODUCTION 1

- Efficacy versus Effectiveness 2
- Treatment Fidelity versus Adaptation 5
- RDM Initiative and the CWD-A Manual 13
- Hypothesized Predictors of CWD-A Manual Adaptation 15
- Summary of Objectives and Hypotheses 20

METHOD 23

- Participants 23
- Measures 24
- Procedures 26
- Data Analyses 26

RESULTS 28

- Patterns of Adaptation 28
- Predictors of Adaptation 29
- Adaptation and Outcomes 32

CONCLUSIONS 35

- Interpretation of Study Findings 35
- Summary 41
- Limitations and Future Directions 43
- Strengths and Implications 46

REFERENCES 49

APPENDIX A 61

Page

APPENDIX B 77

APPENDIX C 83

VITA 93

LIST OF TABLES

		Page
Table 1	Percent of Youths Receiving Each CWD-A Step	83
Table 2	Descriptive Statistics of Manual Adaptation	84
Table 3	Correlations Among Study Variables	85
Table 4	Normality Statistics for Manual Adaptation Variables	86
Table 5	Individual Predictors of Manual Adaptation	87
Table 6	Hierarchical Linear Regressions Predicting Skips from Significant Youth Predictors	88
Table 7	Full Model Hierarchical Linear Regression Predicting Skips from Significant Youth Predictors	89
Table 8	Hierarchical Linear Regressions Predicting Manual Adaptation from Significant Therapist Predictors	90
Table 9	Full Model Hierarchical Linear Regression Predicting Flips from Significant Therapist Predictors	91
Table 10	Hierarchical Linear Regressions Predicting Outcomes from Adaptation	92

INTRODUCTION

The last decades have seen an increasing shift toward the implementation of evidence-based treatments (EBTs) in youth mental health settings, such as community mental health clinics, schools, and juvenile justice settings. This movement has gained momentum as studies have suggested that, while many EBTs for children often yield medium to large effect sizes (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995), the treatment effect for usual care in community clinics is close to zero (Weisz & Jensen, 2001). These findings have led mental health, school, and juvenile justice settings to turn toward EBTs as a potential way to improve outcomes for the youths they serve. Examples of such initiatives are currently taking place in Hawaii, Michigan, and Texas.

In addition, in many cases, the utilization of EBTs offers pragmatic advantages for mental health and justice systems, such as aiding in cost containment (e.g., Henggeler, 1999). Yet, the implementation of EBTs in community settings often constitutes a large undertaking with a number of challenges. Implementation efforts are "a specified set of activities designed to put in practice an activity or program of known dimensions" (Fixsen Naoom, Blasé, Friedman, & Wallace, 2005). Once the decision has been made to adopt a new practice, implementation involves several stages: adopting it in paper, putting the changes in place through workshops, supervision, and changing forms, and making sure the procedures are utilized in a way that their benefits reach the intended consumers (Fixsen et al., 2005). The need to make sure treatments can be replicated in the field and delivered as intended is

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an integral part of this process.

This need has been partly answered with the growing popularity of treatment manuals among treatment developers. These manuals typically include an introduction to the treatment model, an outline of sessions to be completed, and the techniques to be covered in each session in order to achieve treatment goals, although they tend to vary in the level of detail and directives included. Because manuals allow for greater specification of how treatments are to be conducted they can reduce variability attributable to therapists (Crits-Christoph & Mintz, 1991; Henry, Strupp, Butler, Schacht, & Binder, 1993; Piper, Azrin, McCallum, & Joyce, 1990), allowing for more rigorous laboratory studies to determine the efficacy of interventions. Once treatments are determined to be efficacious and ready for dissemination in the field, manuals are thought to be a convenient, low-cost way to facilitate replication of protocols in the community (Addis, Cardemil, Duncan, & Miller, 2006).

However, practicing clinicians often have a number of concerns about using manuals in everyday practice. Among the most common are concerns about whether manualized EBTs are appropriate for clients seen in the community. For example, a focus group of practitioner attitudes toward EBTs found that practitioners were skeptical about this issue due to the tightly controlled nature of clinical trials (Nelson, Steele, & Mize, 2006). This type of concern should not be dismissed easily, as a review of the treatment efficacy and effectiveness literatures suggests.

Efficacy versus Effectiveness

The evidence-based treatments movement has propelled many researchers to validate treatments through clinical efficacy trials. Efficacy studies are conducted in research laboratories and often employ randomized controlled trial (RCTs) designs, which use control

groups and random assignment to eliminate or equalize influences on the dependent variable not due to the treatment itself, thus maximizing the chances of detecting a treatment effect (Nathan, Stuart, & Dolan, 2000). Because RCTs are currently considered the most rigorous research design for evaluating treatments, they are considered the "gold standard" evidence used in reviews of the literature and in EBT lists (Chambless & Hollon, 1998; Nathan & Gorman, 2002).

In addition to maximizing the likelihood of detecting a treatment effect, the exclusion of extraneous variables in these controlled designs also allows for better inference of a causal link between the treatment being tested and changes in the experimental group (Nathan et al., 2000). Laboratory studies thus purposefully control for confounding variables such as high symptom severity and comorbidity (co-occurrence of multiple disorders), and, due to ineffective or narrow recruiting strategies, may inadvertently control for other variables, such as socioeconomic status (SES) or parental psychopathology (Weisz, Donenberg, Han, & Weiss, 1995). Efficacy designs are an important first step in evaluating whether a treatment is successful enough to warrant further study and dissemination.

Yet, as confounding variables such as comorbid conditions, severe symptomatology, resistance to treatment, or suicidality are often found in community clinics, to the extent that these characteristics are excluded from efficacy trials, study populations resemble community populations less and less. Other client characteristics also differ between the laboratory and the clinic: for example, unlike clients in community settings who may be resistant to treatment, clients in efficacy trials are volunteers who are often paid for participating in treatment, and are conceivably more highly motivated to engage and cooperate in treatment. Further, most efficacy studies involve highly motivated clinicians

who undergo extensive training, receive regular quality supervision and monitoring, and have small caseloads (Schoenwald & Hoagwood, 2001). These conditions are unlikely to resemble most community settings, where clinicians often face large caseloads and constrained resources, have large amounts of paperwork to complete, receive minimal training on EBTs and have little time to learn to use them or prepare for sessions, the quality of supervision is highly variable, and monitoring of treatment implementation may or may not take place (Schoenwald & Hoagwood, 2001; Weisz, Chu, & Polo, 2004).

All of these differences between laboratory and clinic settings have resulted in concerns in the field about how well the effects from treatments developed in efficacy trials generalize to clinical settings. In fact, a review of the evidence base concluded only 1% of child outcome studies to date were considered clinically representative on the dimensions of youth, therapist and setting characteristics (Weisz, Doss, & Hawley, 2005).

To address these concerns, some researchers have begun to conduct effectiveness studies. The goal of effectiveness research is to learn whether treatments work in everyday practice settings (Nathan et al., 2000). To achieve this goal, effectiveness designs have few exclusionary criteria and attempt to replicate the setting to which the intervention is destined as closely as possible. While it is hoped that efficacious treatments will be effective, this is not always the case; thus, efficacy studies are likely a necessary but insufficient first step in assessing a treatment's potential for use in community settings (Weisz et al., 2004). Unfortunately, effectiveness designs have been consistently underemphasized in the testing of EBTs, and evidence of the effectiveness of most treatments is scarce (Weisz & Jensen, 2001).

Practitioners' skepticism about the applicability of EBTs to their clients and settings

is therefore not entirely unjustified, and these concerns must be taken seriously if EBTs are to be employed successfully in the community. To the extent clinicians face real obstacles following treatment manuals in community settings, such as more difficult, comorbid clients, less time to prepare for sessions, or inadequate supervision, they might not be able to follow the treatment procedures outlined in manuals exactly, leading to treatment adaptation. On the other hand, it is possible that treatment effectiveness will be compromised if treatments are not implemented by practitioners as they were designed and tested. In order to ensure EBTs succeed in helping children seen in the community, these concerns must also be understood.

Treatment Fidelity versus Adaptation

The adoption of a manual does not guarantee that clinicians will actually use its techniques or do so skillfully. Many have argued that, for a treatment to work, it is important for clinicians to implement the treatment with adherence (actually using the techniques in a manual) and competence (doing so skillfully and with good judgment), a concept called treatment fidelity (Waltz, Addis, Koerner, & Jacobson, 1993).

Treatment fidelity is a key aspect of efficacy studies. As the potency of a treatment can only be judged fairly if it was applied as intended, fidelity measurements represent an indispensible manipulation check in these trials. Monitoring fidelity not only increases statistical power (Moncher & Prinz, 1991), but whether an outcome trial finds positive, adverse, or no effects of a given treatment, without measuring fidelity, the ability to interpret such results can be threatened or greatly weakened. In these cases, it is unclear to what extent treatment success or failure is due to the package itself, its implementation, or other factors (Bellg et al., 2004). It is then surprising that supervision procedures and treatment adherence, the most commonly assessed aspect of fidelity, have only been measured in 32%

of child treatment outcome studies (Weisz et al., 2005).

Interestingly, while it is possible for treatments to be delivered with adherence but in an incompetent manner, competent delivery is thought to encompass adherence (Waltz et al., 1993), although these are not highly related constructs (Miller & Binder, 2002). Yet, because it can be rather costly to measure (Waltz et al.), therapist competence has been even less studied than treatment adherence, and little is known about it.

Within the studies that have measured competence, most have focused on whether each technique within a given treatment is implemented skillfully (Waltz et al., 1993). For example, Waltz et al. discuss how the Cognitive Therapy Scale (Young & Beck, 1980), which measures therapist competence, includes the same skills for each session conducted, even though the Cognitive Therapy of Depression manual (Beck, Rush, Shaw, & Emery, 1979) clearly states techniques should be employed according to a natural course. This type of approach considers techniques in isolation, which may not reflect the universe of actual clinical practice, where practitioners may select or emphasize different techniques according to the individual needs of each client. In fact, some have argued that competent treatment delivery should take into account contextual factors; therefore, it is possible that therapists who tailor treatments to clients based on factors such as stage in therapy, client difficulty, and presenting problems, are more competent than those who do not (Miller & Binder, 2002; Waltz et al.).

Finally, the link between adherence, competence and client outcomes remains unclear (Westen, Novotny, & Thompson-Brenner, 2004). While a few studies have found adherence to predict client progress, others have found it to predict negative outcomes, and still others found no relationship. For example, Luborsky, McLellan, Woody, O'Brien and Auerbach

(1985) found that adherence to cognitive (CT) and supportive-expressive (SE) therapies predicted improved treatment outcomes of adult substance users. Among youths with serious behavior problems, it was found that therapist adherence to Multisystemic Therapy (MST) improved youths' outcomes on a number of domains, including better family relationships, less time spent with delinquent peers, and consequently reduced delinquent behavior (Huey, Henggeler, Brondino & Pickrel, 2000). However, the Vanderbilt II study of Time Limited Dynamic Psychotherapy with adults found no relationship between adherence and clinical outcomes even though the intervention had been implemented with adherence (Bein et al., 2000). Adherence was also not associated with outcomes of depressed adults treated with cognitive-behavioral therapy (CBT) or Interpersonal Therapy (IPT; Elkin, 1999; Shaw et al., 1999). Others have found strict adherence to protocols to interfere with the therapeutic relationship (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

These inconsistencies could be due to methodological differences in studies; for example, when demand characteristics are involved, therapists self-reported adherence may be inflated, reducing the likelihood of finding an effect of adherence on outcomes (Perepletchikova & Kazdin, 2005). It is also possible that these effects are not equal across treatments or even techniques; adherence may only have an impact on outcomes for techniques that actually lead to client change. However, given the incipient state of knowledge of therapy components and mechanisms of change for most EBTs, more research is needed to inform which treatments and components may boast a higher effect of adherence on outcomes.

Findings on the effect of competence on outcomes are also currently mixed. For example, among adults, competent delivery of protocols has been associated with improved

outcomes in with SE and IPT respectively (Barber, Crits-Christoph, & Luborsky, 1996; O'Malley et al., 1988). However, two other studies did not support the association between competence and outcomes (Shaw et al., 1999; Svartberg & Stiles, 1994). While it is possible that competence could be a stronger predictor of outcome, the effects of competence on outcomes have only very rarely been studied (perhaps due to the high cost of measuring competence; Waltz et al., 1993) and more studies are needed to resolve whether this is true.

However, it is possible adherence may influence outcomes only insofar as it is used within therapist competence. To the extent that competence may involve tailoring at the expense of strict manual adherence, it is possible that this adaptation contributes to gains in therapy not achieved with strict adherence. For example, Perepletchikova & Kazdin (2005) discussed how therapists of more disturbed clients were more successful when they modified a treatment protocol to fit client problems (Jones, Cumming, & Horowitz, 1998). They concluded deviations do not necessarily diminish treatment effects, but could lead to more techniques being included, refined, and treatments that are ultimately better matched to certain populations. Other studies in the adult literature have found that strict adherence in psychodynamic or cognitive therapy can have a negative impact on the therapeutic relationship (Castonguay et al., 1996; Henry et al., 1993). This is underscored by the fact that most studies examining the relationship between competence and adherence often no significant relationship between the two (e.g., Bein et al., 2000; Butler, Henry, & Strupp, 1995; Rounsaville, O'Malley, Foley, & Weissman, 1988).

Thus, the current literature on adherence and competence suggests two possible hypotheses about the results of therapists' not adhering to manuals. On the one hand, it may be that, for a treatment to be effective, it needs to be implemented as designed. In the context

of everyday clinical practice, it is conceivable that if practitioners deviate from EBT protocols as a result of untested suspicions that an EBT is ineffective for the population they serve, the potency of the treatment to improve child outcomes would be diminished. On the other hand, it is possible that when therapists do not "adhere" to manuals, it is because they are competently responding to client demands and characteristics. Because of the many differences between laboratory and clinic studies, and because so few effectiveness trials have been conducted with treatments for child disorders, it is possible that EBTs supported by efficacy trials do not work as well with youths with characteristics such as high severity, comorbidity, and low SES as those who seek treatments in community clinics, and that clinicians' concerns about these treatments are justified. These concerns could be further justified by differences in characteristics between these settings, such as high caseloads as well as low pay and supervision in community clinics, or differences among therapists in such settings, such as professional discipline and years of experience. Without empirical investigation, there is no reason to believe treatments that work in laboratory studies would work as well in the highly diversified environment of community clinics, and it is possible that clinicians choose to modify the techniques presented in a manual to deal with these realities of clinical practice.

This second hypothesis suggests that perhaps the term "adherence," which predominates in the literature and implies a "breaking of the rules" when therapists do not follow the contents of a manual exactly, may not be the most appropriate term to study the phenomenon of therapist use of manualized treatments. The current study will use the term "adaptation," which does not assume that employing techniques and sessions creatively will result in negative treatment outcomes for children. It embraces the possibility that the above

modifications could lead to either improved or worsened outcomes, depending on child and therapist characteristics. Further, the present study's operational definition quantitatively explores the patterns of these modifications instead of producing a simple index of deviance from protocols. Provider-level adaptation is thus operationalized as individual therapists' decisions of what techniques to administer within a session, to skip or repeat sessions prescribed by the manual, to alter the order in which sessions are delivered, and to involve parents in youths' treatment.

Thus, to the extent manual adaptation adequately addresses differences in the laboratory and clinic, it could represent an element of competence, enhancing the outcomes of manualized therapy for clients. Alternatively, to the extent adaptation is based on perceived but not real, or real but irrelevant, differences between these settings or populations, it is likely to reduce the effectiveness of EBTs in the community, possibly perpetuating the erroneous assumption they were inappropriate to the community setting to begin with.

While the relative merit of these two hypotheses is an empirical question to be answered, it is known that, even among model prevention programs, adaptation is the rule rather than the exception (Schinke, 2002). This recognition has led to a number of recent efforts toward appreciating the need for local adaptation of programs, including guidelines for how to legitimize and incorporate mechanisms for improving program fit in actual implementation efforts (Backer, 2001). The bulk of these efforts have spoken to program-wide cultural adaptation, with the intent of making programs relevant to ethnic and cultural minorities (e.g., Castro, Barrerra, & Martinez, 2004; Lau, 2006; Solomon, Card, & Malow, 2006). Some studies on the impact of specific culturally adapted programs on youth

outcomes have found positive effects (e.g., Botvin, Schinke, Epstein, Diaz, & Botvin, 1995; Martinez & Eddy, 2005).

Still, most of these guidelines and investigations have been made at the program level, and provider level adaptation remains largely unstudied. Within the realm of cultural adaptation, Ringwalt, Vincus, Ennett, Johnson, and Rohrbach (2004) surveyed substance prevention teachers and found that, in the presence of youth violence, low English proficiency, and different racial and ethnic cultural groups, teachers in schools with more minority students tended to adapt their programs more often than did teachers in schools with a lower proportion of minority students. Taken together with findings supporting program-wide cultural adaptation, these results indicate that cultural diversity is likely a legitimate reason to adapt programs, although it is probably not the only one. However, even when discussing cultural adaptation of programs, researchers caution against haphazard, case by case adaptation that is based not on solid empirical evidence, but on clinical judgment (Lau, 2006).

With respect to treatments, psychotherapists appear no less concerned about the need to adapt protocols than are prevention program teachers and personnel. In fact, the aforementioned survey of child clinicians working under the RDM mandate of Texas also found that 48.1% expressed concerns about the rigidity of treatment manuals; the need to deviate from the protocols was among therapists' top five concerns (Jensen-Doss, Hawley, Lopez, & Osterberg, in press).

However, while psychotherapy researchers have also recognized the need for embracing program adaptation as a central tenet in successful efforts at large-scale implementation of evidence-based services (e.g., Chorpita & Donkervoet, 2005), to my

knowledge there are currently few studies of provider level adaptation in the child psychotherapy literature. An investigation of provider level flexibility (which the authors operationalized as qualitative modification of techniques, not omission or repetition) in treating children with anxiety disorders found no child demographic or comorbidity characteristics to predict how flexibly therapists used manuals (Kendall & Chu, 2000). Further, flexibility was not significantly correlated with multiple measures of child outcomes, and when present, effect sizes were small at best. However, as the study used retrospective recall with 91% of cases rated 1 to 8 years since posttreatment, it is unclear whether such a relationship would be found with measures taken during treatment. Studies utilizing measures taken during treatment, and examining modifications of therapy in a quantitative fashion, are still largely needed.

This gap in the research literature is particularly striking, given: (a) the strong investment of treatment developers in portraying treatments as applicable to real-world settings, (b) the widespread practitioner concerns about the applicability of EBTs to their settings, (c) the largely recognized differences between laboratory and clinic studies, and (d) the possibility that some provider level adaptation is associated with improved client outcomes.

If we are to extend the use of EBTs to reach children treated in community settings, we must understand how treatment providers tend to adapt manualized interventions. Further, we must understand what factors predict lower and higher levels of manual adaptation, what impact this adaptation has on children receiving therapy, and in which instances such adaptation is most appropriate. The RDM initiative of Texas provides an ideal context for such an investigation.

RDM Initiative and the CWD-A Manual

The RDM Initiative of Texas began in 2004, when practitioners working at the state's Mental Health and Mental Retardation clinics were mandated to begin using approved EBTs for different target problems. Approved treatments for child and adolescent mental health problems include the Defiant Children, A Clinician's Manual for Assessment and Parent Training (Barkley, 1997), Defiant Teens, A Clinician's Manual for Assessment and Family Intervention (Barkley, Edwards, & Robin, 1999), and Skills Training for Children with Behavior Disorders, A Parent and Therapist Guidebook (Bloomquist, 1996) for oppositional/conduct problems. The protocols for anxiety disorders are Kendall's Cognitive Behavioral Therapy for Anxious Children (2000), and "The C.A.T. Project" Manual for the Cognitive Behavioral Treatment of Anxious Adolescents (Kendall, Choudhury, Hudson, & Webb, 2002), and for depression the Treating Depressed Children: Therapist Manual for "Taking Action" (Stark & Kendall, 1996), and the Adolescent Coping with Depression Course (CWD-A; Lewinsohn, Clarke, Hops, & Andrews, 1990). Treatments for externalizing disorders are delivered by bachelor-level skills trainers, while those for internalizing conditions are delivered by master's and doctoral-level therapists.

Therapists working under RDM are ideal candidates for an investigation of provider level manual adaptation for a number of reasons: (a) They represent typical providers in community settings required to utilize EBT manuals, (b) they took part in a relatively homogeneous implementation process, (c) this implementation process faced resource constraints likely to be encountered by other states choosing to engage in similar initiatives, and (d) a previous survey of these practitioners (Jensen-Doss, Hawley, et al., in press) has identified they hold a number of concerns identified by clinicians in previous literature

(Addis & Krasnow, 2000; Addis, Wade, & Hatgis, 1999; Strupp & Anderson, 1997).

The CWD-A manual was selected for the current study, as: (a) A large number of youths have been treated with this manual since the inception of RDM; (b) the manual is available electronically free of charge, and is thus potentially accessible to any practitioner in the community; (c) the manual explicitly states that an advantage of using the CWD-A individually is that therapists can adapt the course to each adolescent rather than administer all treatment modules; and (d) the manual is used by therapists versus skills trainers. Therapists working under RDM expressed a higher need to deviate from the manual than did skills trainers (Jensen-Doss, Hawley, et al., in press).

Based on findings that depressed adolescents experience psychosocial issues that are very similar to those experienced by depressed adults (Lewinsohn, Roberts, Seeley, Rohde, Gotlib, & Hops, 1994), Lewinsohn and colleagues adapted the CWD-A from the adult Coping With Depression course (Lewinsohn, Steinmetz, Antonuccio, & Teri, 1984). The CWD-A is a psychoeducational group course containing 16 sessions that is designed to be nonstigmatizing, to teach skills to enhance moods and coping with difficult situations, to use group skills and role-play and to be cost-effective (Lewinsohn, Clarke, Rohde, Hops, & et al., 1996). While developed and tested in a group format, the CWD-A manual states it can be adapted for individual therapy, which is how it is used by practitioners working under Texas' RDM.

The CWD-A was originally tested in two clinical efficacy trials comparing the CWD-A alone, the CWD-A plus parent involvement, and a waitlist control condition. The first trial found both treatment conditions had significant pre- to post-treatment changes in all of the many dependent variables employed. At post-treatment, 46% of treated adolescents

had remitted, compared to 5% of controls, and by the 6-month follow up 83% of treated adolescents had remitted (Lewinsohn et al., 1990). The second outcome trial also found both treatment groups to improve significantly more than the control condition, and across both trials few to no differences between both treatment conditions were found (Lewinsohn et al., 1996).

These trials were conducted by graduate students in the helping disciplines who were extensively trained in an 8-week seminar, whereas RDM practitioners are practicing clinicians and received only a 2-day workshop on the whole range of RDM treatments. Participants were also excluded from the trials if they had a number of comorbid conditions (such as Bipolar, Panic, Generalized Anxiety, or Substance Use Disorders, as well as psychotic experiences, brain damage, or mental retardation). The samples also contained primarily White youths (87% and 99% White, respectively; Rohde, Lewinsohn, & Seeley, 1994). These differences suggest some hypotheses about what factors are likely to predict manual adaptation, discussed below.

Hypothesized Predictors of CWD-A Manual Adaptation

While provider-level adaptation of the CWD-A program has not been previously studied, prior studies on the CWD-A program efficacy, prior work on provider adaptation of prevention programs, and surveys of provider opinions about EBTs suggest several possible factors that might lead therapists to adapt the CWD-A, including youth and therapist predictors, and several youth and therapist moderators that might be associated with greater effectiveness of such adaptation.

Youth Factors

The efficacy trials of the CWD-A suggest several youth characteristics expected to be associated with higher rates of adaptation and to moderate the effects of this adaptation on outcomes, as there were several youth characteristics that predicted less improvement in the CWD-A validation samples. However, these variables are only expected to truly influence therapist behavior and lead to more adaptation when therapists perceive that these variables will have an impact on treatment outcomes. Hypotheses regarding youth characteristics were therefore formulated by balancing the CWD-A literature with theories regarding therapists' perceptions.

In the first CWD-A clinical trial, worse outcome was associated with a lower number of past diagnoses and higher intake depression levels, measured as Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores (Clarke, Hops, Lewinsohn, Andrews, et al., 1992). The second clinical trial also found worse outcomes to be associated with having higher initial levels of depression, as well as with being older, and being female (Lewinsohn, Clarke, & Rohde, 1994).

Therefore, it was hypothesized that higher symptom severity, as measured by Ohio Scale scores (the closest proxy to depression scores in the current study), would be a predictor of adaptation (because therapists are likely to have expectations about the appropriateness of treatment for more severe clients) It was also expected that adaptation could be more appropriate (acting as a moderator) for clients who are older and female, but these variables were not expected to predict adaptation since, dissimilar from severity, it is unlikely that therapists would have prior expectations that the manual is less appropriate for these clients.

In terms of ethnicity, two efforts to make the CWD-A more relevant to minority adolescents adapted the course for use with incarcerated Hispanics (Sanchez-Barker, 2003), and Native American adolescents in school settings (Listug-Lunde, 2005). However, only the latter studied efficacy of the modification, finding most depression symptoms improved at a faster (but not higher) rate of improvement for children in the modified intervention versus a control group. Additionally, both these efforts pertained to adapted CWD-A interventions. Since RDM is utilizing the original CWD-A manual, which was designed and tested with largely White samples, it is expected its therapists will tend to perceive ethnic minority youths as targets for manual adaptation. This hypothesis is consistent with prevention research findings that teachers were more likely to adapt programs in schools composed by a higher number of minority status students (Ringwalt et al., 2004).

Further, previous research of another child treatment, Multisystemic Therapy (MST), has repeatedly found caregiver-therapist ethnic (and occasionally gender) mismatch to predict therapist adherence to manuals, a related construct to adaptation (Halliday-Boykins, Schoenwald, & Letourneau, 2005; Schoenwald, Halliday-Boykins, & Henggeler, 2003; Schoenwald, Letourneau, & Halliday-Boykins, 2005). However, MST therapists work intensively with caregivers (Schoenwald et al., 2005) whereas RDM therapists using the CWD-A work primarily with youths themselves; therefore, youth-therapist gender and ethnic mismatch was hypothesized to result in higher manual adaptation in the present study.

A more recent study compared the effect of the CWD-A versus a Life Skills intervention (comprised of independent living skills education) for children with comorbid depression and conduct problems (Rohde, Clarke, Mace, Jorgensen, & Seeley, 2004). This study utilized a blended efficacy/effectiveness design with youth randomized to conditions,

but youth were referred from a real-world setting (the Juvenile Service System), there were no comorbidity exclusions, and youth were allowed to receive treatment as usual in both conditions. Youths in both conditions improved on depressive symptoms, social adjustment, and functioning, with the CWD-A group improving significantly more by post-treatment; however, there were no significant differences between conditions at 6 and 12-month follow-ups. Further, neither group improved significantly on conduct symptoms at any time point, or on secondary outcome measures such as service utilization or improvement on other comorbid conditions. These results are in line with other findings on the attenuated effects of the CWD-A, modified and delivered in a school setting, for children with comorbid disorders (Esposito, 2005).

These findings suggest comorbidity could influence the impact of adaptation on outcomes. Further, since the belief that comorbidity does diminish treatment efficacy is still widespread among clinicians (Addis et al., 1999), I hypothesize higher manual adaptation will be associated with higher comorbidity rates.

In line with these hypotheses, lower therapist ratings of functioning (measured as scores on each of the the CA-TRAG Domain Rating scales or scores on the Ohio Functioning Scale) were also expected to prompt more adaptation. This is consistent with a review of therapists' open ended responses to the aforementioned RDM survey (Osterberg et al., in progress), which identified therapists were often concerned about the inappropriateness of the RDM manuals for low functioning clients.

Finally, as youths in the CWD-A validation samples were likely to be more affluent than youths typically seen at MHMR (the former utilized volunteers at a Health Management Organization, whereas the latter serves typical clients presenting to community clinics), it

was anticipated that therapists would believe the CWD-A to be less appropriate for clients with low Socioeconomic Status (SES), leading themto adapt the intervention more for these clients. SES was therefore included in predictor analyses.

To summarize, it was hypothesized therapists would tend to adapt the CWD-A more for youths who: (a) belong to an ethnic minority, (b) were ethnically mismatched to their therapist, (c) were gender mismatched to their therapist, (d) had more diagnoses (comorbidity) at intake, (e) had higher severity of symptoms at intake, (f) were lower functioning at intake, and (g) had lower SES. In addition, (h) age and (i) gender were not expected to predict higher adaptation, since it was unlikely therapists would have access to the scarce and conflicting research data about the treatment being more effective for older females, and since no prior findings indicate what practitioners might expect about the need to adapt in relation to these variables.

Therapist Factors

Previous research suggests a number of factors that may be associated with provider's tendency to adapt manuals and the effectiveness of such adaptation. For example, Addis & Krasnow (2000) found that practitioners with fewer years of experience were significantly more likely to hold favorable views about treatment manuals, although this difference was small. Similarly, Aarons (2004) found that interns in the helping professions were significantly more likely to have positive attitudes toward EBTs than were staff. These results resonate with clinical judgment research findings that practitioners with more years of experience are more confident in their judgments (Garb, 1998), and with findings that they tend to adhere less to protocols (see Perepletchikova & Kazdin, 2005). Thus, it was hypothesized that therapists with more years of experience would be less likely to hold

positive views about manuals and be more confident in themselves, resulting in a stronger tendency to make adaptations to the CWD-A manual.

In addition, gender and ethnicity of therapists were be analyzed in an exploratory fashion with no a priori hypotheses about the direction of their effects on manual adaptation. Therefore, it was hypothesized that therapists would adapt more when (a) they had more years of experience, and the effects of therapist (b) gender and (c) ethnicity on adaptation were explored.

Summary of Objectives and Hypotheses

The current study aimed to address the identified gap in the implementation literature by examining patterns of adaptation of the Coping with Depression Course-Adolescent (CWD-A; (Lewinsohn et al., 1990) among child therapists working under the RDM mandate of Texas. Further, in order to shed light on the conditions that generate manual adaptation, it also examined what, if any, child and therapist characteristics predict manual adaptation among community service providers, and the impact of adaptation on outcomes.

Patterns of Manual Use

The term "session" will hereon be used to refer to any given therapy appointment in which a therapist was expected to meet with a child and cover the CWD-A, regardless of which part of the manual was or was not covered. The term "step", however, will refer to the CWD-A's 16 steps (each of which, coincidentally, therapists are expected to cover within one session), each of which contains specific manual content that is to be presented in a specific order (step 1 followed by step 2, followed by step 3, and so on). To understand how the CWD-A was being adapted, the following areas were explored: (a) Are therapists repeating steps from the CWD-A manual?, (b) Are therapists skipping steps from the CWD-

A manual?, and (c) Are therapists presenting steps in a different order than suggested in the manual?

H1. Predictors of Manual Adaptation

For each type of adaptation described above, the following predictor hypotheses were examined:

H1a. Youth Predictors of Manual Adaptation. Therapists will tend to adapt the CWD-A manual more for youths who: (a) belong to an ethnic minority, (b) are ethnically mismatched to their therapist, (c) are gender mismatched to their therapist, (d) have more diagnoses (comorbidity) at intake, (e) have higher severity of symptoms at intake, (f) are lower functioning at intake, and (g) have lower SES. The effects of (h) age and (i) gender was be examined exploratorily, since no prior findings indicate what practitioners might expect about the need to adapt in relation to these variables.

H1b. Therapist Predictors of Manual Adaptation. Therapists will tend to adapt the CWD-A manual more when they: (a) have more years of experience The effects of therapist (b) gender and (c) ethnicity on adaptation were explored.

H2. Impact of Manual Adaptation on Youth Therapy Outcomes

It was hypothesized adaptation would be significantly related to youth outcomes. However, because the nature of the adaptation construct does not assume a positive or negative effect on outcomes, impact on therapy outcomes will be analyzed exploratorily. Treatment outcomes were measured by examining changes in symptom severity and functioning as assessed by children's parent-reported Ohio Problem Severity and Functioning Scale scores gathered in assessment time points after the child's intake assessment. Thus impact on youth outcomes was examined in the following ways: (a) Does repeating steps

have an impact on youth outcomes?, (b) Does skipping steps have an impact on youth outcomes?, and (b) Does the order of steps completed have an impact on youth outcomes?

A visual model of the study's framework and hypotheses is depicted below.

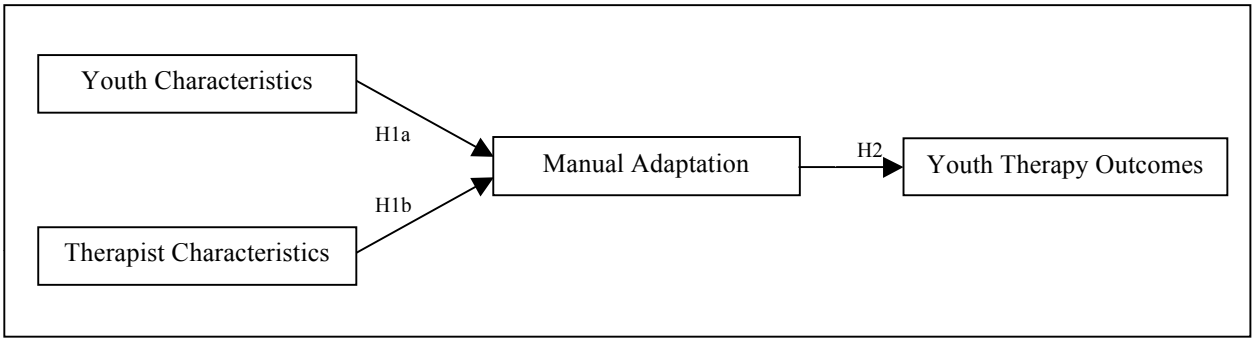

Figure 1. Manual Adaptation and Youth Outcomes Framework.

METHOD

Participants

Participants were 288 youths ages 14 to 18 (*M* = 15.21, *SD* = 1.24) who were treated with the CWD-A manual at Texas' Harris County Mental Health and Mental Retardation (MHMR) Clinics between September 2004 and the time of data retrieval (June 2008). The sample was 56.6% female, and included primarily Hispanic youths (52.8%), followed by African-Americans (23.3%), Caucasians (17.7%), Asians (5.6%), and youths of "Other" ethnicities (0.7%). As might be expected in these settings, youths' families had low annual incomes (*M* = $18,376.57, *SD* = $11,153.78). Further, youths' initial symptom severity as measured by the Ohio Scales was, on average, clinically significant. Clinical significance for the Ohio Problem Severity Scale is defined as scores of 21 and above and clinical significance in the Ohio Functioning Scale is defined as scores of 49 and below (Ogles, Dowell, Hatfield, Melendez, & Carlston, 2004). The present sample scored on average 44.26 on the Ohio PS (*SD* = 13.13), and 30.52 on the Ohio F (*SD* = 15.42). In terms of comorbidity, youths had on average 1.91 mental health diagnoses (*SD* = .85); however, this range is artificially restricted to 0-3, since the MHMR data storing system only collects information about the presence of a maximum of 3 axis I diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) at any given time.

It should be explained that in order to capture the full extent to which adaptation might have occurred during treatment, only youths whose cases were no longer active were be included in the study. However, since information about official treatment closing dates was not available from the clinics for the timeframe of this study, inactive cases were defined

as those in which the child's last CWD-A therapy session was followed by a period of at least 90 days in which the child did not receive any therapy services. Under this coding scheme, children could have returned to treatment after this 90-day period, but sessions occurring after such period were not included in this study since the treatment plan after such an extended period would have to be considerably revised due to likely changes in the child's development, or potentially the remittance of the previous depression/emergence of new concerns.

The youths in the present sample were treated by 38 therapists; however, therapist information was not available for 4 therapists. Therefore, the subsequent demographics are based on the 34 therapists for whom such information was available. Therapists in the current sample were primarily female (82.4%), and ranged in age from 31 to 63 years old (M = 44.76, SD = 9.70). The therapist sample included predominantly Caucasians (44.1%), followed by African-Americans (38.2%), Hispanics (11.8%), Asians (2.9%), and "Other" ethnicities (2.9%). Therapists had on average 28.83 years of experience working for TDMHMR (SD = 5.34); however, information on field experience prior to employment at TDMHMR was not available. Finally, 97.1% of therapists held master's degrees (50% M.A., 29.4% M.S., 11.8% M.Ed.), and 2.9% held a bachelor's degree (B.S.). Data for children treated by all 38 therapists were included in the analyses, except for those predicting adaptation from therapist characteristics.

Measures

Depressed Teen Progress Notes

These progress notes have been used by Harris County's MHMR clinics for youths treated with the CWD-A since the inception of RDM. A different template is available for

each session. Each template contains a checklist of the specific techniques that should have been covered in that session, as well as a list of the homework assignments outlined in the manual for that session. The Depressed Teen Progress Notes templates are provided in Appendix A.

Ohio Scales

The Ohio scales are comprised of the Ohio Problem Severity (PS) Scale, a 20-item measure of children's psychological symptoms, the Ohio Functioning (F) Scale, a 20-item measure of children's functioning, and the Ohio Total Problems Scale. There are parallel forms for parents, workers, and youths to complete. The Ohio scales have been demonstrated to be highly reliable and valid and correlate well with other established measures of similar constructs. For example, the original validation study of the Ohio Scales found the Ohio PS Scale to correlate .89 with the Child Behavior Checklist's Total Problems Scale (Ogles et al., 2004). A study of the Ohio Scales with children served by Texas RDM found Cronbach's alpha for the parallel forms of the PS Scale to fall at .90 and above, for both standardized and raw item scores. Additionally, alphas for the parallel forms of the F Scale were .92 and above for both standardized and raw item scores (Texas Department of State Health Services, 2003). The Parent, Worker, and Youth Forms of the Ohio Scales are shown in Appendix B.

Demographic and Clinical Information

Demographic information kept by MHMR was used to describe the sample and in the analyses of child characteristics as predictors of manual adaptation. Specifically, children's age, gender, ethnicity, family income, and family size were obtained, as were children's diagnoses as assigned by MHMR staff. Therapist information obtained included age, gender, ethnicity, years employed at MHMR, and degree.

Procedures

The present study utilized archival data collected routinely in the process of assessment and therapy of youths treated with Major Depression and related disorders at Harris County MHMR. A staff member at MHMR identified all adolescents who received counseling for depression since the inception of RDM and start of use of the CWD-A in September, 2004. All data gathered from paper charts (Depressed Teen Progress Notes) were de-identified and coded by the PI at MHMR's storage location where files for closed cases were kept. If a chart containing a previous course of treatment with the CWD-A had been reopened, it was either brought to the storage location for coding, or coded at the clinics via PI visits pre-arranged by MHMR records staff. A staff member at MHMR also de-identified all data stored electronically prior to providing it to the PI.

Data Analyses

Patterns/Typology of Manual Adaptation

Descriptive statistics were be used to describe average length of treatment, the number of sessions repeated, skipped or delivered out of order. In order to describe patterns of adaptation, a typology of manual adaptation was developed. Therapists were called "double-dippers" if they administered any given session more than once; "skippers" if they administered a later session without ever administering a prior session, and "flippers" if they administered later sessions before administering prior sessions (excluding complete "skips"). Therapists could fall under multiple categories under this scheme.

Study Hypotheses

Specific hypotheses were analyzed with Random Coefficients Modeling, to account for the group level nature of therapist data, and for the nested nature of client data (clients

nested under therapists). Slope error terms were estimated as random effects whenever possible; in cases where this was not possible, slope error terms were treated as fixed. The following equations were used to test study hypotheses:

H1a. Youth Predictors of Manual Adaptation. Each hypothesized predictor will be tested with the following equations:

Level 1: $Y_{ij} = \beta_0 + \beta_1 (X_{ij} - X_j) + r_{ij}$

Level 2: $\beta_0 = \gamma_{00} + U_{0j}$

$\beta_1 = \gamma_{10}$

Where Y_{ij} represents the index of manual adaptation, X_{ij} represents youth predictors, and X_j represents the grand mean of the respective youth predictor.

H1b. Therapist Predictors of Manual Adaptation. Each hypothesized therapist predictor will be tested with the following equations:

Level 1: $Y_{ij} = \beta_0 + r_{ij}$

Level 2: $\beta_0 = \gamma_{00} + \gamma_{00}G_j + U_{0j}$

Where Y_{ij} represents the index of manual adaptation, and G_j represents therapist predictors.

H2. Impact of Manual Adaptation on Youth Therapy Outcomes. This relationship (with manual adaptation represented by an aggregate index) will be tested with the following equations:

Level 1: $Y_{ij} = \beta_0 + \beta_1 X_{ij} + r_{ij}$

Level 2: $\beta_0 = \gamma_{00} + U_{0j}$

$\beta_1 = \gamma_{10} + U_{1j}$

Where Y_{ij} represents youth therapy outcomes, and X_{ij} the index of manual adaptation.

RESULTS

Patterns of Adaptation

Youths received on average 5.26 CWD-A sessions (*SD*= 4.70, 1-28). CWD-A sessions, or "steps" delivered were heavily negatively skewed, with the vast majority of children receiving earlier but not later steps from the manual (e.g., 80.6% of youths received step 1, 51.0% received step 2, 30.2% received step 3, etc.; see Table 1 in Appendix C).

In addition, 92.1% of therapists were "double-dippers", 55.3% were "skippers", and 43.2% were "flippers". Among youths, 69.4% received double-dips, 29.5% received skips, and 20.9% received flips. Further, among youths who did receive some form of manual adaptation, the average number of double-dips, skips and flips was quite high given youths' length of treatment ($M = 4.21$, $SD = 3.74$; $M = 3.00$, $SD = 3.40$; $M = 1.23$, $SD = .56$; respectively). Table 2 in Appendix C includes complete statistics on manual adaptation.

Correlations between the types of adaptation were calculated to determine whether they represented distinct constructs (see Table 3 in Appendix C for correlation matrix). Double-dips and skips were not significantly related to each other ($r = .06$, $p = .31$), but double-dips and flips were ($r = .30$, $p < .01$), as were skips and flips ($r = .16$, $p = .01$).

In order to further explore these patterns, chi-squares were conducted to determine the likelihood a youth who received one type of adaptation (i.e., double-dips), also received each of the other types of adaptation (i.e., skips and flips). The measure of effect size for used these analyses was φ. Further, $\varphi = .10$ was regarded as a small effect, $\varphi = .30$ a medium effect, and $\varphi = .50$ a large effect (Cohen, 1988). Chi-squares revealed that youths who had sessions double-dipped were significantly more likely to also have had sessions skipped than were youths who did not receive double-dips (and vice-versa), although this effect was small

[χ^2 (1, N = 288) = 7.82, p < .01, φ = .17]. In addition, youths who had received double-dips were significantly *less* likely to have had sessions flipped than were youths who did not receive double-dips (and vice-versa); this was a large effect [χ^2 (1, N = 288) = 68.30, p < .01, φ = -.50]. Finally, youths who had sessions skipped were no more likely to have had sessions flipped than youths who did not receive skips (and vice-versa) [χ^2 (1, N = 288) = .17, p = .68, φ = .02].

Predictors of Adaptation

In order to verify the appropriateness of using Random Coefficients Modeling, the Intraclass Correlation Coefficient [ICC(1)] was computed for both predictor and outcome variables. In this context, ICC(1) indicates the proportion of total variance [in a variable] attributable to group membership, with ICC(1) values of .10 (10% variance explained) or greater indicating enough variability due to groups that non-independence in the data is expected (Bliese, 2000; Raudenbush & Bryk, 2002). Results indicated nesting of youths within therapists explained a large portion of variability in each dependent variable, including the three indices of manual adaptation (double-dips, skips, and flips; ICC(1) = .24, .53, and .36, respectively), and the two indices of youth therapy outcomes (Ohio PS and F scales; ICC(1) = .13 and .10, respectively). Thus, all subsequent analyses were conducted via multilevel models using the Hierarchical Linear and Nonlinear Modeling statistical package (HLM 6.02a; Raudenbush, Bryk, & Congdon, 2005).

Further, since the length of youths' course of treatment varied widely, it became clear that the opportunity to observe each behavior described as manual adaptation would also vary per youth. For example, a youth receiving 16 weeks of treatment would have many more opportunities to have sessions repeated, skipped or flipped than would a youth

receiving a two-week long course of treatment. Therefore, it was hypothesized that the manual adaptation variables may not be normally distributed. Indeed, skewness and kurtosis of these variables were irregular (see Table 4 in Appendix C).

In order to address these violations of an important assumption of hierarchical regression (namely, that residuals in these variables must be normally distributed; Raudenbush & Bryk, 2002), predictor analyses were conducted based on a Poisson distribution with variable exposure rather than on a normal distribution (Atkins & Gallop, 2007; Elhai, Calhoun, & Ford, 2008). The total number of CWD-A sessions received by each youth was entered as the variable exposure factor. This strategy is expected to help reduce the impact of varying lengths of treatment on the manual adaptation variables as dependent variables in the predictor analyses.

As a result, Poisson regression coefficients were obtained in the predictor analyses. These coefficients must be exponentiated prior to interpretation, and the yielding statistic represents the magnitude of the increase or decrease in odds of the occurrence of the measured outcome (odds ratio; OR), for each one unit increase in the predictor variable. Coefficients and OR's for each individual predictor analysis of manual adaptation are given in Table 5 (Appendix C).

Study Hypotheses

H1a. Youth Predictors of Manual Adaptation. It was not possible to estimate slope error terms as random effects for all models of youth predictors of manual adaptation. Therefore, to maintain consistency across this set of analyses and aid in interpretability of results, slope error terms were treated as fixed for all analyses involving child predictors of manual adaptation.

No client characteristics significantly predicted double-dips or flips. However, skips were significantly predicted by youths' family income, initial problem severity and functioning, ethnic identity, and ethnic match with their therapist. Specifically, therapists skipped more sessions for children with higher income, with a 34.4% increase in skips for each standard deviation increase (*SD* = $11,153.78) in yearly income (*OR* = 1.34). In addition, therapists skipped more sessions for youths with higher initial severity. Specifically, therapists skipped 32.5% more sessions for each standard deviation increase (*SD* = 13.13) in youths' Ohio PS intake score (*OR* = 1.33).

Ethnicity analyses excluded youths of "other" ethnicity, due to that group's extremely small sample size (*n* = 1). Relative to Caucasian youths, therapists skipped 42.8% fewer sessions for African-American youths (*OR* = 0.57), 42.9% fewer sessions for Hispanic youths (*OR* = 0.57), and 62.5% fewer sessions for Asian youths (*OR* = 0.37). Finally, youths who were ethnically matched to their therapists received 43.8% more skips (*OR* = 1.44). Table 6 in Appendix C provides a summary of the impact of significant child predictors of skips.

Once significant client predictors of adaptation were identified, a full model was planned for skips to determine each significant predictor's independent contribution to skips. No full models were planned for double-dips or flips, since no youth characteristics were found to predict these types of adaptation.

Table 7 (Appendix C) depicts the results of the full model predicting skips. It should be noted that when entered together, youths' family income and pre-treatment severity remained significant predictors of skips, as did being Hispanic or Asian (relative to being Caucasian). However, being African-American and being ethnically matched to one's

therapist no longer significantly predicted skips.

H1b. Therapist Predictors of Manual Adaptation. Slope error terms were treated as random effects in all models of therapist predictors of manual adaptation. In contrast with the association of client characteristics with skips, no therapist characteristics were found to significantly predict skips. However, therapists employed longer at MHMR tended to double-dip more often than more recently hired staff, with an 11.5% increase in double-dips per standard deviation increase (*SD* = 5.34) in years of employment at MHMR (*OR* = 1.11). Finally, male therapists flipped 48.9% less sessions than did female therapists (*OR* = 0.51), and Hispanic therapists flipped 75.0% less sessions than did Caucasian therapists (*OR* = 0.25). Therapist ethnicity analyses did not include therapists of Asian or "Other" ethnicity, due to these subgroups' extremely small sample size (n=1 and n=1). No other therapist predictors of adaptation were significant; complete statistics for these models are provided in Table 8 (Appendix C).

Again, since more than one therapist predictor was found for flips, a full model was built including all significant therapist predictors of flips (see Table 9 in Appendix C). However, this model revealed that when entered together, being Hispanic continued to significantly predict fewer flips relative to Caucasians (*OR* = 0.11), but being male did not (*OR* = .05).

Adaptation and Outcomes

Since RDM requires youths to be assessed every 90 days, and youths' length of treatment varied, the number of outcome measures available for each youth was also variable. To analyze these repeated measures, linear models were constructed predicting each outcome data point from the time elapsed since treatment entry. Because initial severity and

functioning were significantly associated with higher skips and could account for the effect of adaptation on outcomes, it was deemed necessary to control for these variables in the analyses. However, since initial severity and functioning values were also used to construct the linear models of change, entering them as predictor variables of change over time would create co-linearity in the data (as initial severity would serve as both an independent and dependent variable). To circumvent this challenge, base linear models, without any predictor variables, were constructed with HLM software to generate empirical Bayes estimates of each child's slope in symptom severity and functioning.

Two-level HLM models (youths nested within therapists) were then constructed with adaptation as predictors of these slope estimates (change over time) outcome variables, controlling for length of treatment. Slope error terms were treated as random effects in all models of manual adaptation and outcomes.

H2. Impact of Manual Adaptation on Youth Therapy Outcomes. Model intercepts indicated that the average youth was improving during treatment, as evidenced by significant negative slopes for the Ohio PS scale and significant positive slopes for the Ohio F scale (see Table 10 in Appendix C). Results revealed that double-dips were associated with worse treatment outcomes as measured by the Ohio PS scale, with a 0.007 point decrease in the amount of change occurring in Ohio PS scores per week, per double-dip ($p < .01$). However, skips were associated with associated with better treatment outcomes, such that each skip was associated with a 0.003 increase in the amount of in change in Ohio PS scores per week ($p < .05$). Finally, flips were associated with worse treatment outcomes in terms of functioning scores as measured by the F scale, such that each flip was associated with a 0.003 decrease in the amount of improvement obtained in functioning, per week ($p = .05$). A

complete description of the effects of manual adaptation on youths' therapy outcomes is provided in Table 10 in Appendix C.

CONCLUSIONS

The current study attempted to clarify in what ways community therapists tend to adapt an EBT for depression on an individual basis, and what association such adaptation has with children's therapy outcomes. Using a therapist self-report measure of manual use, adaptation was classified as double-dipping (i.e., repeating steps), skipping (i.e., skipping steps), and flipping (i.e., administering sessions in an order that differed from what was indicated in the manual).

Interpretation of Study Findings

Patterns of Manual Use

Findings are striking and suggest a number of implications. First, while the length of treatment at these community clinics varied widely (0-28 sessions), and while the longest courses of treatment were certainly long enough to cover the entire 16 weeks of necessary to complete the CWD-A, the average duration of treatment was quite short (5.26 sessions). Whereas EBTs have been criticized for being too short (Westen, Novotny & Thompson-Brenner, 2004), our results suggest this was certainly not the case with youths seen at MHMR. In fact, the evidence suggests that in a community settings such as ours, youths may not attend treatment long enough for therapists to be able to use an EBT such as the CWD-A, perhaps because youths in such low income community settings have too many life stressors or face too many barriers to attend a 16-week course of treatment. This phenomenon is also likely to occur in other community clinics, as our average length of treatment is consistent with the average treatment length reported in previous studies of child therapy (i.e., Kazdin et al., 1990; Weisz, Weiss, et al., 1987).

Equally important, the fact that intraclass correlations were considerably greater than

.10 for each of the adaptation variables suggests that a large proportion of variance in youths' course of treatment is attributable to which therapist a youth is treated by. In other words, more often than not, therapists in this sample are adapting treatment systematically across their caseloads rather than case by case. Given that clients are not randomly assigned to therapists in these clinics, this could be a result of therapist characteristics or habits, or of the types of clients each therapist typically sees. As mentioned previously, one advantage of treatment manuals is that they are believed to reduce variability in treatment delivery that is due to therapists. However, our large intraclass correlation values also suggest that, in this sample, the adoption of the CWD-A treatment manual was not sufficient to reduce variability due to therapists to a non-detectable level.

Further, our greater than .10 intraclass correlations for pre-treatment severity indicates another group effect: some therapists treated more severely symptomatic children than others. However, pre-treatment severity was only significantly correlated with skips, suggesting that working with more severe children was not generally a rationale therapists may have used for adapting treatment.

In addition, therapists did not appear to be using the CWD-A as intended by treatment developers. First, therapists seem to be primarily focused on the early sessions in the manual. Eighty percent of children received the first step from the manual and 50% of children received step 2, but only a moderate to minimal proportion of youths received the skills building portions of the manual (steps 3-15). Paired with the fact that children received 5 sessions on average, this suggests that therapists are relying heavily on the rapport building parts of the manual, but not administering the more "active ingredients" of the treatment very often.

Second, therapists reported rampart adaptation: virtually all therapists double-dipped sessions, with two thirds of youths receiving double-dips (4.21 per child, on average). Skips were less common, but still highly prevalent with roughly half the therapists skipping CWD-A steps altogether, and roughly one third of children having steps skipped (3.00 on average). Finally, flips were least common, but were still performed by 43.2% of therapists and received by roughly one fifth of the sample (1.23 on average).

What makes these findings particularly striking is that they arguably represent the best-case scenario for how closely these clinicians were following the manual. The present study used self-reported indices of manual use, the Depressed Teens Progress Notes. These notes are part of MHMR's Fidelity Toolkit, designed to measure adherence to RDM's treatment and system of care parameters. In addition, RDM therapists are aware that these notes may be used to monitor their work performance. Thus, given the pressure associated with the Progress Notes, it is likely that, if anything, results represent an underestimation of the amount of manual adaptation present in the present sample.

The fact that the percentages of therapists engaged in these various forms of adaptation was higher than the percentages of youths receiving such adaptation indicates that therapists were applying these modifications to only a subset of their clients. A next important question was whether this selection was made systematically (based on either youth or therapist characteristics) or not, and whether these adaptations had an impact on child treatment outcomes.

Double-Dips. Theoretically, it is likely that therapists would choose to double-dip, or repeat, steps if a youth did not seem to understand the content of a step, or was not able to practice the learned skills at home and needed further demonstration/problem solving to

implement the skill. While the current study did not examine whether understanding of sessions was associated with double-dips, it is possible that certain youth characteristics would be associated with the need to repeat steps. For example, therapists could perceive that children with higher number of diagnoses or symptom severity might require a higher dose of the intervention and therefore need steps repeated more often, or that a subset of children belonging to ethnic minorities may also have linguistic difficulties that would result in the need to double-dip. Therefore, it is striking that despite theoretical reasons to assume that child characteristics might be associated with double-dips, the choice to double-dip was not systematically associated with any youth characteristics. Double-dips were associated with one therapist predictor, however; namely more years of employment at the clinics.

There were conceptual reasons to think that therapist characteristics might also be related to double dipping. For example, one potential "therapist-based" reason for choosing to repeat sessions could simply be that some therapists like administering some CWD-A steps better than others. As mentioned above, more youths were administered earlier steps. Early CWD-A steps (e.g., 1 and 2), are more open-ended, allowing for greater therapist flexibility, such as more time spent building rapport or discussing topics the therapist finds important at any given moment. Should certain therapists wish to incorporate elements from other interventions/theoretical orientations, as was allowable prior to RDM, these CWD-A steps would also be the most accommodating to such an approach. The finding that therapists who had been employed at MHMR longer tended to double-dip more often than therapists who were novice to the system seems congruent with previous literature suggesting that therapists with more years of experience tend to hold less positive attitudes towards EBTs, and that they also tend to rely more on their clinical judgment (Garb, 1998; see also

Perepletchikova & Kazdin, 2005). This may certainly have been the case with our sample, where it is likely that therapists who had more experience in the system had worked for MHMR prior to being mandated to use EBTs, and thus had a greater history of relying on their other treatment approaches.

Finally, it is also noteworthy that each double-dip was associated with reduced improvement in symptom severity. This could mean that therapists' choice to repeat steps was detrimental to children's outcomes. However, no information is available about the directionality of the effects adaptation on outcomes. Therefore, it is possible that some children were not appearing to respond to treatment, and that this lack of response led therapists to double-dip more for those children.

Skips. The fact skips were predicted by youth factors suggests therapists were more systematic in their choice to skip. The decision to skip steps is likely to result from therapists' judgment that certain skills are not as relevant to certain clients. Our findings suggest that this may have been the case for children with higher annual family income, of Hispanic and Asian ethnicity relative to Caucasians, and those with higher initial problem severity.

In terms of income, it had been hypothesized that therapists would adapt the manual more for youths with lower family income, given that the CWD-A was developed on a more affluent sample than those seen at MHMR. However, the opposite was found. It may be that therapists felt that children with fewer resources were in greater need of the structure and skills offered in the CWD-A and were therefore less likely to skip sessions for these youths.

In addition, also contrary to hypotheses, therapists skipped more sessions for Caucasian youths than for certain ethnic minorities (Hispanics or Asians). This suggests that,

rather than perceiving the treatment as less adequate for children of ethnic minorities, therapists may have felt more confident about working with Caucasian children, and therefore felt more free to adapt treatments with those children.

Finally, congruent with our hypotheses, therapists tended to skip more sessions for youths with greater symptom severity. This indicates that therapists likely felt that some CWD-A sessions were not as appropriate for more symptomatic youths (perhaps hypothesizing that these youths would have more difficulty understanding the content of some steps).

In terms of outcomes, skips were associated with greater improvement in symptom severity. One possibility is that skips *led* to greater improvement, corroborating the idea that some CWD-A sessions were inappropriate for some of the youngsters. However, since the directionality of the effect of skips on outcomes is not determinable from the current design, it is also possible therapists increased their amount of skipping for those youths who showed a better response to the CWD-A. Either way, whether skipping sessions was an appropriate type of adaptation (resulting in better outcomes) *for these severely symptomatic youth*, who were more likely to receive skips, is a question that remains to be answered.

Finally, although we hypothesized skips would be associated with therapist characteristics, these analyses were not significant. Yet, since our analyses suggested there was enough variability in skips that was attributable to therapists, it is likely that other, unmeasured, therapist characteristics exist that predict skips.

Flips. Flipping steps might be expected if therapists perceived that some youths could benefit from receiving steps in a different order than prescribed by the CWD-A manual. For example, if a youth seemed very tense at the outset of treatment, a therapist might choose to

begin with Step 3 – Reducing Tension, or Step 8 – Relaxation, to provide the youth with a skill that could bring some immediate relief, and then go back to cover Steps 1 and 2 on later sessions. However, as with double-dips, flips were not significantly related to any youth characteristics. This suggests therapists likely did not perceive value in changing the order of sessions for any particular profiles of youths.

It is possible that flipping could also be related to therapist characteristics. For example, if a therapist valued a particular later step more than earlier steps, he or she might tend to administer that step earlier in treatment across all clients. We found that Hispanic therapists flipped many more steps than Caucasian therapists did (78% more). This suggests that Hispanic therapists are more comfortable beginning treatment with some of the later steps, but that they do tend to go back and cover previous steps subsequently.

Finally, we found a relationship between flipping and worse treatment outcomes. As with our other outcome findings, the lack of directionality information about the effects means that flips could have *led* to worse outcomes in functioning, or that therapists noticed that some children were not improving in other domains of living as well as others, and thus chose to alter the order steps were delivered in an attempt to adjust to such a scenario.

Summary

The main finding of the present study is that, in this community setting, therapists are using the CWD-A in vastly different ways than it was intended. While some adaptation appears broad and unsystematic (e.g., double-dips and flips), therapists also appear to be skipping sessions in an attempt to respond to client characteristics. Yet, whether such adaptation is indeed more appropriate for the clients selected to receive it is a question that must answered via additional moderator analyses.

In addition, there is also evidence that therapists have personal habits in treatment delivery, even with a manual such as the CWD-A, and that some therapists are more likely to adapt the manual, with some of these findings being congruent with theory stemming from previous literature (e.g., therapists with longer tenure tending to repeat more sessions), and others appearing more stylistic (Hispanic therapists' association with more flips). These differences also suggest that some clinicians are less likely to "buy in" to delivering the treatment as intended than others. Further, whether these differences suggest that some therapists' tendency to adapt is justified given the population they work with, or whether they simply point to greater resistance in adopting an innovation is a question that moderator analyses will need to address.

Finally, each type of manual adaptation was related to treatment outcomes, in unique patterns. The diversity of these predictor and outcome relationships suggests each type of manual adaptation is a unique construct and important to study on its own. In addition, while the magnitude of these effects was small, the fact that effects were detectable even in a sample with such short average length of treatment is noteworthy. However, given the non-experimental nature of the present design, the directionality of the effect of adaptation on outcomes is unclear. This is particularly problematic in the current scenario, since outcomes were associated with adaptation in ways that would indeed be expected should therapists be using treatment response as a source of information on which to decide whether to adapt: specifically, double-dips might be an appropriate response to worse improvement (and were indeed associated with less improvement in our sample), and skips might be an appropriate response to more improvement (and were indeed associated with greater improvement in our sample). Therefore, more information is needed to fully understand what drives specific

types of adaptation, and the impact of each on youth outcomes.

Limitations and Future Directions

Several limitations of the current study must be considered when interpreting its results. First, while some youth predictors of adaptation were identified, and while adaptation was indeed associated with increased or decreased improvement in symptom severity and functioning, it is still unclear whether double-dipping, skipping and flipping were *more appropriate or effective* choices for those youths with whom therapists chose to adapt treatment. On the same token, it is also unknown whether therapists who adapted more often did so more appropriately than did therapists who adapted less often. In other words, in order to understand what implementation strategies are most effective in community settings such as this one, we must understand not only what child and therapist characteristics are associated with adaptation, but also those that *moderate* the relationship between adaptation and treatment outcome. Only then will enough information be available to determine whether treatment adaptation is an appropriate response to client (or therapist) characteristics.

In addition, a comparison of predictors and moderators of manual adaptation could also reveal whether the youths therapists are choosing to adapt more with are also those for whom adaptation is most effective. Further, it could also be determined whether the therapists who adapt the most are the ones who engage in more effective adaptation. In that sense, the absence of moderator analyses is a limitation of the present study, but one that is expected to be addressed in the near future with data from this same sample – a step that future studies should also aim to address.

The second main limitation is that the current study was unable to determine whether adaptation impacts treatment outcomes, or whether adaptation is a response to how clients

are responding to treatment. While this is a difficult issue to address, it is an important one, for even if moderator analyses reveal specific child profiles are associated with greater effectiveness of adaptation, this effect could be secondary to the fact these children are non-responders to begin with. Thus, future investigations should attempt to remedy this challenge by collecting brief symptom measures each session so that it could be determined whether adaptation is a response to treatment failure, or whether it contributes to worse outcomes. In addition, the present study did not control the effect of other services received concurrently with the CWD-A. It is possible that services other than the CWD-A were responsible for client improvement. Therefore, controlling for other services might help clarify the association of the CWD-A with client improvement, in a further attempt to shed light on whether lack of treatment response could have led to adaptation rather than result from it. As a result, future studies should also aim to control for the effects of other services received concurrently with the treatment in question.

Further, the present study relied on self-report data, rather than observational data. As mentioned above, therapists may have felt pressured to report lower rates of adaptation; however, the high rates of adaptation observed in this study suggest this was likely not a significant problem. This lack of observational data also means that the quality with which the steps were delivered (i.e., therapist competence) cannot be ascertained. Future studies employing observational data would help address these issues.

The Depressed Teen Progress Notes used were also not able to capture the potential addition of elements from alternate treatment approaches in youth's treatment, making it impossible to determine the extent to which treatment contamination occurred. Therefore, future research should attempt to measure not only elements omitted from the treatment in

question, but elements included from other approaches.

While examining a number of types of adaptation, this investigation focused primarily on the inclusion or exclusion of treatment steps. However, this type of analysis does not shed light on which specific parts of treatment are more likely to be adapted and what the result is of including, skipping or double-dipping on specific treatment components. To address this limitation, future research should also aim to focus on analyses oriented at describing the specific contents of treatment aspects covered or omitted.

It was also only possible to examine the impact of a very limited set of therapist characteristics on treatment adaptation. For example, differences in provider might also be related to therapists' training discipline; a recent survey of psychology, psychiatry, and social work programs across the country found the latter offer the least amount of coursework and supervision in EBTs (Weissman et al., 2006), with only fewer than half of programs requiring coursework and supervision in at least one EBT (Bledsoe et al., 2007). Therefore, it is possible that social workers would adapt treatments more often (since they likely lack experience with them), but that when they do, adaptation would have less of a positive impact on outcomes relative to adaptation from professionals in other disciplines (who are likely to have received more training in EBTs and be more familiar with when and how changes to protocols should be made). However, information about training discipline was not available for the present study. Other potential predictors, such as therapist caseload size or income were also not available, and another did not have enough variability in the present sample to be useful as a predictor (therapist degree). Future investigations should thus attempt to examine as many potentially relevant therapist characteristics as possible.

Finally, the present findings nay not generalize to other EBTs, or to systems of care

where implementation is not mandated of therapists. Research on manual adaptation under those conditions will help clarify the impact of adaptation in various circumstances.

Strengths and Implications

Despite these limitations, the present investigation has a number of strengths. First, it is, to my knowledge, the first study to date to study manual adaptation from a provider-level perspective. Second, it created a typology of multiple facets of manual adaptation that can help pave the way for future studies to better understand these important constructs. Third, the data collected supported that the three types of adaptation identified here do indeed appear to represent independent constructs, since distinct patterns of relations among double-dips, skips, and flips emerged both in the correlation matrix and in the chi-square analyses. Fourth, the present study constitutes a genuine effectiveness study in a "real-world" setting that is likely to be representative of other states wishing to implement EBTs, and mandating their use. Fifth, it includes therapists who share concerns of clinicians surveyed on previous literature (Jensen-Doss, Hawley, et al., in press). Sixth, it counted on a large sample of youths. Finally, it employed statistical methods appropriate for the nested nature of this data, helping shed light on an important, understudied phenomenon that has the potential to influence costly and time-consuming dissemination efforts.

In addition, the current findings suggest a number of implications, particularly when the goal of an institution is to implement treatments as intended. First, efforts to implement EBTs must consider whether the proposed treatment fits the circumstances of the setting. For example, it may be unrealistic to expect therapists to adequately implement a 16-session long treatment in clinics where the average treatment length of depression-focused psychotherapy is 5 sessions. In such cases, alternate treatments may be selected or developers may be

approached as to how best to shorten the treatment, prior to implementation.

Second, combined with the fact that adaptation was rampart among the sample, and that therapists shied from more skill-based sessions, it is possible that therapists could need more intensive training or supervision on the CWD-A to become more comfortable with the treatment in general. While RDM therapists reported feeling they received adequate training in the selected treatments (Jensen-Doss, Hawley, et al. in press), previous authors have suggested that workshops alone are insufficient for therapists to incorporate new interventions via changes in practice (e.g. Fixsen et al, 2005). In addition, a previous study also found that even community therapists who were satisfied with a 2-day workshop training in an EBT perceived themselves as using that EBT's skills more often than they actually were (Jensen-Doss, Cusack, & DeArellano, in press).

Third, therapists' greater reliance on earlier steps of the manual indicates they are engaging in easier practices of rapport building and open-ended discussion. This suggests that training efforts may benefit from devoting more time to increase clinician's competence in more skills-based parts of treatments that may be least liked or harder to implement.

Fourth, given that some therapists were more likely to adapt than others (e.g., Hispanic therapists, or those with more years of experience at the clinics), trainers and systems of care should strive to better understand which groups of therapists are likely to alter treatments post-training, so they can prepare with particular care to find ways to increase "buy-in" from these groups.

Above all, treatment developers and system administrators should be aware that when transported to a community clinic setting (even to therapists mandated to use them), EBTs are likely to undergo a vast amount of adaptation, as was the case in our sample. Therefore, it

is crucial to provide therapists with as much specific guidance as possible about what conditions may warrant repeating, skipping, or flipping treatment steps. Indeed, it is quite possible that lack of specific, systematic guidance about how to customize the CWD-A to their clients' needs contributed to RDM therapists adapting the treatment idiosyncratically.

Because such practical guidance can ultimately only be generated with more research on the effects of different types of adaptation on outcomes, more studies are needed to understand provider-level manual adaptation. However, until such information is available, developers and trainers must use theory to assist therapists in deciding with whom, under what circumstances, and how to adapt EBTs.

While the lack of knowledge about provider-level manual adaptation reflects the developmental state of the field, this deficiency must not be allowed to continue. If we are to honor well-intentioned states undergoing vast mental health transformations to incorporate EBTs, the therapists required to use them, and the children receiving these services, provider-level manual adaptation must be better understood. Only then can the potential of these state-of-the-art treatments be maximized, rather than wasted through uninformed or haphazard modifications.

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APPENDIX A

PROGRESS NOTES

Consumer Name: _____ Case #: _____ Unit Name: _____ Location: _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 1 – Depression and Social Learning**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Assisted adolescent in completing the "Beginning of the Course" Mood Questionnaire (workbook Appendix)
- ☐ Discussed rules for CBT sessions (workbook page 1.3)
- ☐ Discussed the idea that learning to control our lives is a skill
- ☐ Presented the four criteria for a positive social interaction and helped the adolescent to identify things he/she does well
- ☐ Discussed how to be a friendly person by: ☐making eye contact ☐smiling ☐saying something positive about the other person ☐telling about yourself (questions 1,2, and 3 on workbook page 1.4)
- ☐ Assisted adolescent in selecting one friendly skill to work on
- ☐ Interacted with adolescent allowing him/her to tell about self while practicing positive interaction skills
- ☐ Provided constructive feedback to adolescent regarding use of positive interaction skills (questions 4 & 5 on workbook page 1.4)
- ☐ Outlined the three aspects of each individual's personality that contributes to depression: feelings and emotions, actions, and thoughts (workbook page 1.5)
- ☐ Discussed how depression can be viewed as a downward spiral, and how to change it into an upward spiral (workbook page 1.6)
- ☐ Explained to the adolescent how to use and fill out the Mood Diary (workbook page 1.1)

In session practice:

- ☐ Modeled/role-played appropriate interaction skills
- ☐ Modeled how to give constructive feedback
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See page 1.7 of workbook)

- ☐ Adolescent to have conversations with people he/she knows and practice friendly skills
- ☐ Adolescent to keep track of feelings by completing Mood Diary (workbook page 1.1)
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 2 – Self-Observation and Change**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Assisted adolescent in recognizing appropriate times to start a conversation (question 1 on workbook page 2.1)
- ☐ Identified good questions for starting conversations (questions 2 & 3 on workbook page 2.1)
- ☐ Demonstrated how to do a simple baseline count (workbook page 2.2)
- ☐ Discussed reasons why baselining is important
- ☐ Assisted adolescent in identifying pleasant activities that have the most influence on mood (workbook page 2.3)
- ☐ Assisted adolescent in selecting 20 activities that he/she would like to study and eventually increase (workbook pages 2.4 & 2.5)
- ☐ Provided adolescent with instructions for baselining pleasant activities
- ☐ Instructed adolescent to take the quiz on self-observation and change on page 2.7 of the workbook

In session practice:

- ☐ Modeled/role-played how to initiate a conversation
- ☐ Modeled the use of "conversation-starter" questions
- ☐ Role-played appropriate and inappropriate conversation starting with the adolescent
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See page 2.6 of workbook)

- ☐ Adolescent to try and start 2 conversations with another person
- ☐ Adolescent to take baseline data on pleasant activities each day (workbook page 2.4)
- ☐ Adolescent to fill out Mood Diary each day (workbook page 1.1)
- ☐ Adolescent to continue to practice "friendly skill" found on page 1.2 of the workbook (goal #1)
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 3 - Reducing Tension**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Instructed adolescent to present new ideas for conversation-starter questions based on new things he/she has noticed about people
☐ Taught adolescent skills for meeting new people: guidelines for being introduced, choosing greetings, remembering people's names, and shaking hands
☐ Discussed the greetings found on workbook page 3.1
☐ Discussed that tension can get in the way of things that are necessary to overcome depression
☐ Assisted adolescent in assessing whether tension is a barrier (workbook page 3.2)
☐ Introduced the Jacobsen Relaxation Technique
☐ Assisted adolescent in identifying critical situations in which t to use the Jacobson Relaxation Technique (workbook page 3.3)
☐ Instructed adolescent to complete the quiz on page 3.5 of the workbook, and discussed the adolescent's answers

In session practice:

☐ Modeled/role-played how to gauge first impressions
☐ Modeled/role-played the four introduction skills
☐ Practiced the introduction skills with the client
☐ Modeled/role-played the use of the Jacobsen Relaxation Technique
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See page 3.4 of workbook)

☐ Adolescent to practice using the Jacobsen Relaxation Technique 3 times
☐ Adolescent to continue to record pleasant activities daily (workbook 2.4)
☐ Adolescent to fill out the mood diary daily (workbook page 1.1)
☐ Adolescent to continue to practice friendly skills, including starting conversations and introductions
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression** **Step 4 - Learning How to Change**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Discussed the three critical ingredients for learning to change: recognizing that you can learn how to change, believing that you can change, developing a plan for change
- ☐ Assisted the adolescent in understanding how to chart baseline activities using pages 2.4 and 4.1 of the workbook
- ☐ Assisted the adolescent in understanding how to chart baseline moods using pages 1.1 and 4.1 of the workbook
- ☐ Discussed how to choose realistic and appropriate goals (workbook page 4.2)
- ☐ Educated adolescent on choose a goal based on mood level, typically staying at or above level 3
- ☐ Reviewed the characteristics of good goals: they are both specific and realistic (workbook page 4.3)
- ☐ Instructed adolescent to set a goal for the number of pleasant activities for each day (record on workbook page 1.2)
- ☐ Assisted adolescent in identifying patterns in pleasant activity levels (workbook page 4.4)
- ☐ Assisted the adolescent in developing strategies for increasing the number of pleasant activities
- ☐ Discussed rules for selecting rewards and instructed adolescent to create a list of rewards that they have control over (wb page 4.5)
- ☐ Taught adolescent how to develop a personal contract (workbook page 4.6)
- ☐ Assisted the adolescent to complete the quiz on learning how to change on page 4.8 of the workbook

In session practice:

- ☐ Demonstrated how to chart baseline data
- ☐ Demonstrated how to choose a mood goal
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See page 4.7 of workbook)

- ☐ Adolescent to try and meet goal for Session 4 (maintaining pleasant activities at a specific level)
- ☐ Adolescent to continue recording his/her pleasant activities (workbook page 2.4)
- ☐ Adolescent to continue to fill out the Mood Diary daily (workbook page 1.1)
- ☐ Adolescent to practice the Jacobsen Relaxation Technique
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 5 - Changing Your Thinking**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Discussed practical suggestions for increasing pleasant activities (questions 1 & 2 on workbook page 5.1)
- ☐ Assisted adolescent in developing one important strategy for improving success rate on the Pleasant Activities Contract
- ☐ Assisted adolescent in evaluating goal for pleasant activities and making appropriate adjustments
- ☐ Taught adolescent how to join and leave conversation groups
- ☐ Discussed that people can learn to control and change their thinking (questions 3 & 4 on workbook page 5.1)
- ☐ Assisted adolescent in identifying most frequent negative and positive thoughts (workbook pages 5.2 , 5.3 & 5.4)
- ☐ Taught adolescent how to determine ratio of positive to negative thoughts (workbook page 5.5)
- ☐ Discussed activating events (workbook page 5.6)
- ☐ Gave feedback to the adolescent as he/she identified negative thoughts and activating events in cartoon sequences
- ☐ Taught adolescent how to record (for the following week) their worst negative thoughts, the activating events that made them think that way, and the number of times they catch themselves thinking negatively (workbook page 5.7)
- ☐ Instructed adolescent to complete the quiz on changing your thinking on page 5.9 of the workbook

In session practice:

- ☐ Modeled/role-played how to enter and leave conversation groups
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See page 5.9 of workbook)

- ☐ Adolescent to increase pleasant activities so that he/she can consistently meet daily goal on page 4.6 of the workbook
- ☐ Adolescent to record his/her goal for session 5 on page 1.2 of the workbook
- ☐ Adolescent to continue recording pleasant activities workbook page 2.4)
- ☐ Adolescent to continue to fill out the Mood Diary (workbook page 1.1)
- ☐ Adolescent to practice the Jacobsen Relaxation Technique
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

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Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression** **Step 6 - The Power of Positive Thinking**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Assisted adolescent in coming up with at least one positive statement about another person (workbook page 6.1)
- ☐ Assisted adolescent in writing down positive statements about self that have been offered by others (workbook page 6.2)
- ☐ Taught adolescent how to distinguish between personal and nonpersonal negative thoughts (workbook page 6.3)
- ☐ Assisted adolescent in using baseline information to make a list of the negative personal thoughts that are most troublesome (from workbook page 5.7)
- ☐ Instructed adolescent to complete "My Most Troublesome Negative Personal Thoughts" (workbook page 6.9)
- ☐ Discussed how to use positive thoughts to counter negative thoughts (workbook pages 6.4 & 6.5)
- ☐ Provided feedback as adolescent identified irrational beliefs in cartoon sequences and suggested more positive, rational beliefs (workbook pages 6.6 and 6.7)
- ☐ Assisted adolescent in developing positive counter-thoughts and beliefs for negative thoughts (workbook page 6.8)
- ☐ Assisted adolescent in completing the "Positive Counter-thoughts" (workbook page 6.9)
- ☐ Instructed adolescent to record a goal for session 6 on page 1.2 of the workbook
- ☐ Assisted adolescent in writing a contract and selecting a reward for meeting negative thinking goal (workbook page 6.10)
- ☐ Instructed the adolescent to complete the quiz on the power of positive thinking on page 6.12 of the workbook

In session practice:

- ☐ Modeled/role-played how to use positive thoughts to counter negative thoughts
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 6.11)

- ☐ Adolescent to catch him/herself thinking negatively at least once daily and change the thought to a positive one
- ☐ Adolescent to continue filling out the Negative Thoughts Baseline (workbook page 5.7)
- ☐ Adolescent to continue to fill out the Mood Diary (workbook page 1.1)
- ☐ Adolescent to work on goal for pleasant activities (page 4.6 of the workbook)
- ☐ Adolescent to practice the Jacobsen Technique
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

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Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 7 - Disputing Traditional Thinking**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Assisted adolescent in identifying irrational beliefs in cartoon sequences and replacing them with positive counter-thoughts (workbook pages 7.1, 7.2 & 7.3)
☐ Assisted adolescent in converting nonpersonal thinking to personal thinking by identifying the activating event and describing his or her personal reaction to it
☐ Introduced the ABC method to describe our thoughts: Activating Event – Belief – Consequence (workbook pages 7.4, 7.5 & 7.6)
☐ Introduced the CAB method for analyzing feelings (Consequence – Activating Event – Belief)
☐ Discussed the steps of the CAB method in depth with the adolescent (workbook page 7.7)
☐ Presented and discussed other ways to deal with activating events: don't respond to them, change the way we respond to them, avoid them, change them, and cope with them; Completed workbook page(s): ☐7.8 ☐7.9 ☐7.10 ☐7.11 ☐7.12
☐ Assisted adolescent in completing the quiz on disputing irrational thinking on page 7.14 of the workbook

In session practice:

☐ Modeled/role-played how to apply the ABC method
☐ Modeled/role-played how to apply the CAB method
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 7.13)

☐ Adolescent to analyze a personal situation by using the CAB method and filling out a thought diagram once daily
☐ Adolescent to continue recording negative thoughts and positive counter-thoughts on workbook page 6.10
☐ Adolescent to continue to fill out the Mood Diary (workbook page 1.1)
☐ Adolescent to continue to work on meeting goal for maintaining a satisfactory level of pleasant activities
☐ Adolescent to use the Jacobsen Relaxation Technique
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 8 - Relaxation**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Assisted adolescent in analyzing a cartoon sequence using the CAB method (workbook pages 8.1 & 8.2)
- ☐ Discussed habits that turn other people off (workbook page 8.3)
- ☐ Assisted adolescent in giving and receiving feedback on their experience of using friendly skills
- ☐ Assisted the adolescent in identifying his/her two most offensive social habits
- ☐ Identified situations in which it is difficult to use the Jacobsen Relaxation Technique immediately before a situation
- ☐ Introduced the Benson Relaxation Technique (workbook pages 8.4 & 8.5)
- ☐ Guided the adolescent through the use of the Benson Relaxation Technique
- ☐ Introduced the Quick Benson Relaxation Technique
- ☐ Guided the adolescent through the use of the Quick Benson Relaxation Technique
- ☐ Assisted the adolescent in completing the quiz on relaxation on page 8.7 of the workbook

In session practice:

- ☐ Modeled/role-played appropriate friendly skills
- ☐ Modeled the Benson Relaxation Technique
- ☐ Modeled the Quick Benson Relaxation Technique
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 8.6)

- ☐ Adolescent to practice the Benson Relaxation Technique 4 times and record on session goal record on workbook page 1.2
- ☐ Adolescent to fill out the CAB form when he/she catches self thinking a negative thought or when he/she starts to feel depressed.
- ☐ Adolescent to continue to fill out the Mood Diary (workbook page 1.1)
- ☐ Adolescent to continue working on goal for maintaining a satisfactory level of pleasant activities
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 9 - Communication, Part 1**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Assisted the adolescent in completing workbook page 9.1
- ☐ Discussed the communication process in terms of sending and receiving information
- ☐ Educated on and demonstrated nonverbal communication
- ☐ Introduced and discussed the concept of a communication breakdown (workbook page 9.2)
- ☐ Introduced the 3 Types of Responses: ☐the irrelevant response ☐partial listening ☐active listening
- ☐ Assisted the adolescent in using active-listening skills (workbook page 9.3)
- ☐ Discussed how to use restatements to improve communication (workbook page 9.4)
- ☐ Explained and discussed the difference between judgmental responses and understanding responses (workbook pages 9.5 & 9.6)
- ☐ Assisted the adolescent in completing the quiz on communication on workbook page 9.8

In session practice:

- ☐ Modeled nonverbal communication
- ☐ Modeled the 3 types of responses
- ☐ Modeled/role-played the use of restatements
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 9.7)

- ☐ Adolescent to practice the active listening daily and record on session goal record on workbook page 1.2
- ☐ Adolescent to practice restating a sender's message daily and record the results on workbook page 9.9
- ☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
- ☐ Adolescent to continue working on goal for maintaining a satisfactory level of pleasant activities
- ☐ Adolescent to practice relaxation using the Benson or Jacobsen techniques
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

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PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression** **Step 10 - Communication, Part 2**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Educated how to phrase positive feeling statements in the form of an activating event and a personal-feeling reaction (workbook page 10.1)
- ☐ Discussed how to make helpful personal statements by using the self-disclosure approach (workbook page 10.2)
- ☐ Discussed how to express negative feelings by naming the activating event and the feeling reaction (workbook page 10.3)
- ☐ Reviewed the guidelines for making helpful self-disclosure statements about negative feelings (workbook pages 10.4 & 10.5)
- ☐ Demonstrated how to use the A-B-C method to sort out problem situations and negative feelings (workbook pages 10.6 & 10.7)
- ☐ Assisted the adolescent in completing the quiz on communication on workbook page 10.9

In session practice:

- ☐ Modeled nonverbal communication
- ☐ Modeled the 3 types of responses
- ☐ Modeled/role-played the use of restatements
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 10.8)

- ☐ Adolescent to practice stating positive feelings using the A-B-C method and record on workbook page 10.10
- ☐ Adolescent to practice using self-disclosure by expressing 2 negative feelings
- ☐ Adolescent to analyze a problem situation each day by using the A-B-C forms on workbook pages 10.11 through 10.14
- ☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
- ☐ Adolescent to practice using active listening skills
- ☐ Adolescent to continue working on goal for maintaining a satisfactory level of pleasant activities
- ☐ Adolescent to practice using relaxation techniques
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 11 - Negotiation and Problem Solving, Part 1**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Introduced the concept of assertive-imagery practices
☐ Presented the 4 steps of assertive-imagery: 1)make a mental photograph of the situation, 2)convert the photograph into a movie, 3)state your feelings, 4)imagine the other person's reaction (workbook page 11.1)
☐ Discussed the importance of problem-solving and negotiating skills
☐ Assisted adolescent in generating a list of conflicts that come up between friends and with parents
☐ Discussed the basic rules for successful problem-solving (workbook page 11.2)
☐ Discussed the 8 rules for defining a problem: 1)begin with something positive, 2)be specific, 3)describe what the other person is doing or saying that's creating a problem for you, 4)no name-calling, 5)express your feelings, 6)admit your contribution to the problem, 7)don't accuse or blame others, 8)be brief (workbook page .11.3)
☐ Assisted adolescent in completing the quiz on negotiating and problem-solving on workbook page 11.5

In session practice:

☐ Modeled/role-played using assertive imagery
☐ Modeled/role-played problem solving and active listening skills
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 11.4)

☐ Adolescent identify several problems and practice defining the them using the 8 rules (workbook page 11.6)
☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
☐ Adolescent to practice using active listening skills
☐ Adolescent to continue working on goal for maintaining a satisfactory level of pleasant activities
☐ Adolescent to practice using relaxation techniques
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 12- Negotiation and Problem Solving, Part 2**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Discussed the rationale and rules for brainstorming: 1)list as many solutions as you can, 2)don't be critical, all ideas are allowed, 3)be creative, 4)begin by offering to change one of your own behaviors (workbook page 12.1)
☐ Presented a systematic method for narrowing down the list of ideas generated during the brainstorming stage (workbook page 12.2)
☐ Discussed how to write a contract that spells out the details of a solution: use exact wording, be specific, describe what each person will do and the consequences of failing to uphold agreement, specify period of time, include reminders (workbook page 12.3)
☐ Assisted adolescent in putting the steps together for problems-solving and negotiation (workbook page 12.4 & 12.5)
☐ Assisted adolescent in completing the quiz on negotiating and problem-solving on workbook page 12.8

In session practice:

☐ Modeled/role-played brainstorming
☐ Modeled/role-played evaluating solutions
☐ Role-played using all of the steps for problem-solving and negotiating
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 12.6)

☐ Adolescent to complete the Issues Checklist with parents (workbook pages 12.11 through 12.15)
☐ Adolescent to complete the sample brainstorming and evaluation situations on workbook pages 12.9 and 12.10
☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
☐ Adolescent to practice using active listening skills
☐ Adolescent to continue working on goal for maintaining a satisfactory level of pleasant activities
☐ Adolescent to practice using relaxation techniques, particularly in stressful situations
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

MHMRA

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression** **Step 13 - Negotiation and Problem Solving, Part 3**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Guided adolescent through a complete problem-solving and negotiation session of mild to moderate intensity, using problems selected from the previously competed Issues Checklist (workbook page 13.1)
☐ Assisted adolescent in defining the problem, using active listening, going through the problem-solving steps, and writing a contract (workbook pages 13.2 & 13.3)
☐ Assisted adolescent to develop a positive approach for convincing LAR to learn problem-solving techniques (workbook page 13.5)

In session practice:

☐ Role-played using all of the steps for problem-solving and negotiating
☐ Modeled/role-played adolescent convincing LAR to learn problem-solving techniques
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 13.4)

☐ Adolescent to decide on the time and place to present the idea of problem-solving to LAR
☐ Adolescent to go through the teaching procedure at the bottom of workbook page 13.5 with LAR
☐ Adolescent to practice problem-solving with LAR – follow steps on workbook page 13.1, take notes on workbook page 13.7, complete contract on workbook page 13.8, follow through with written contract
☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

MHMRA

MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 14 - Negotiation and Problem Solving, Part 4**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Guided adolescent through a complete problem-solving and negotiation session of moderate intensity, using problems selected from the previously competed Issues Checklist (workbook page 14.1)
☐ Assisted adolescent in defining the problem, using active listening, going through the problem-solving steps, and writing a contract (workbook pages 14.2)

In session practice:

☐ Role-played using all of the steps for problem-solving and negotiating
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 14.3)

☐ Adolescent to decide on the time and place to ask LAR to participate in another problem-solving practice session
☐ Adolescent to practice problem-solving with LAR – follow steps on workbook page 13.1, take notes on workbook page 14.5, complete contract on workbook page 14.6, follow through with written contract
☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

MHMRA

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 15 – Life Goals**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

- ☐ Reviewed topic(s) from previous session
- ☐ Reviewed homework from previous session
- ☐ Assisted adolescent in distinguishing between long-term and short-term goals
- ☐ Discussed the need to be specific and realistic in setting long-term goals
- ☐ Assisted adolescent in determining goals in specific areas of life (workbook page 15.1)
- ☐ Discussed several fears/obstacles that can hold people back from reaching goals, and discussed some ways to overcome them
- ☐ Assisted adolescent in completing the quiz on life goals on workbook page 15.3

In session practice:

- ☐ Modeled/role-played identifying realistic goals
- ☐ Modeled/role-played identifying plans for overcoming obstacles
- ☐ Other:

Reward system:

- ☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
- ☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 14.3)

- ☐ Adolescent to continue to fill out the Mood Diary on workbook page 1.1
- ☐ Adolescent to practice using Benson and Jacobsen relaxation techniques, especially in stressful situations
- ☐ Adolescent to begin recording pleasant activities again (workbook page 15.4 or 2.4)
- ☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

PROGRESS NOTES

Consumer Name: _____ **Case #:** _____ **Unit Name:** _____ **Location:** _____

Each note should address the following: type of service/intervention statement; mode of delivery (e.g. Face-to-face) & who received,the service; problem and intervention used matches what is on the POC; progress or lack of progress toward POC goals; signature/title of author.

Date	Start Time	Stop Time	Service Code	Note
			3300	**Cognitive Behavioral Therapy for Adolescents with Depression Step 16 – Prevention, Planning and Ending**

Met face-to-face with: ☐ Consumer ☐ Consumer and LAR ☐ Consumer and Family

Topics for session:

☐ Reviewed topic(s) from previous session
☐ Reviewed homework from previous session
☐ Assisted adolescent in completing the "End of the Course" Mood Questionnaire (workbook Appendix) and compared with the "Beginning of the Course" Mood Questionnaire completed in the first session
☐ Discussed the need to maintain the gains the adolescent has made in learning and practicing new skills
☐ Discussed the need to minimize the effect of everyday hassles
☐ Assisted adolescent in identifying how to cope with everyday hassles (workbook page 16.1)
☐ Assisted adolescent in emergency planning: identify major life events, consider how these events will affect behavior, and identify a prevention plan (workbook page 16.2)
☐ Educated adolescent on early recognition of depression (workbook page 16.3)
☐ Prepared for termination by reviewing what adolescent had learned, expressed pride of adolescent's progress, and discussed the importance of continuing to make use of techniques learning in coping with depression

In session practice:

☐ Modeled/role-played coping with everyday hassles
☐ Modeled/role-played emergency planning
☐ Other:

Reward system:

☐ Discussed and established reward system to reinforce the correct use of new skills and generalize in natural settings
☐ Reward system not yet implemented

Demonstrated understanding of content area:

☐poor ☐fair ☐good ☐excellent

Clinical observations:

Progress towards treatment goals:

Homework assigned (See workbook page 14.3)

☐ Adolescent to continue to make use of learned techniques in coping with depression
☐ Other:

Staff Signature/Credentials	_____

REC: 036 (Rev. 7/00) **Location:** Office, Client's home, School, Daycare center, Family child care, Employment site of consumer, Jail/juvenile center, HCPC hospital, Another community site, Medical facility, detention center(X), IMD-Psych hospital(Z)

APPENDIX B

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Parent Rating – Short Form

P

Child's Name: _____ Date: _____ Child's Grade: ___ ID#: _____ Completed by Agency

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
   1. Extremely capable
   2. Moderately capable
   3. Somewhat capable
   4. Somewhat incapable
   5. Moderately incapable
   6. Extremely incapable
3. How much stress or pressure is in your life right now?
   1. Very little
   2. Some
   3. Quite a bit
   4. A moderate amount
   5. A great deal
   6. Unbearable amounts
4. How optimistic are you about your child's future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

W

Agency Worker Rating – Short Form

Child's Name: _____ Date: _____ Child's Grade: ___ ID#: _____

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: _____ ☐ Case Manager ☐ Therapist ☐ Other: _____

Instructions: Please rate the degree to which the designated child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Markers:

School Placement: _____

Current Psychoactive Medications: _____

Markers (Continued):	Number in Past 90 Days
Arrests *(any arrest by police or officer of the court)*	_____
Suspensions from School *(count of all instances of suspension from school by school officials)*	_____
Days in Detention *(days in a detention facility)*	_____
Days of School Missed *(all school days missed for any reason)*	_____
Self-Harm Attempts *(count of all instances of self-harm attempts that are reported or observed)*	_____

ROLES: Enter the number of days the youth was placed in each of the following settings during the past 90 days. (For example, the youth may have been in a detention center for 3 days, a group home for 7 days and with the biological mother for 80 days.)

_____	Jail	_____	Foster Care
_____	Juvenile Detention Center	_____	Supervised Independent Living
_____	Inpatient Psychiatric Hospital	_____	Home of a Family Friend
_____	Drug/Alcohol Rehabilitation Center	_____	Adoptive Home
_____	Medical Hospital	_____	Home of a Relative
_____	Residential Treatment	_____	School Dormitory
_____	Group Emergency Shelter	_____	Biological Father
_____	Residential Job Corp/Vocational Center	_____	Biological Mother
_____	Group Home	_____	Two Biological Parents
_____	Therapeutic Foster Care	_____	Independent Living with Friend
_____	Individual Home Emergency Shelter	_____	Independent Living by Self
_____	Specialized Foster Care	90	***(Total for the two columns should equal 90)***

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Youth Rating – Short Form (Ages 12-18)

Y

Name: _____ Date: _____ Grade: _____ ID#: _____ (Completed by Agency)

Date of Birth: _____ Sex: ☐ Male ☐ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
   1. Extremely healthy
   2. Moderately healthy
   3. Somewhat healthy
   4. Somewhat unhealthy
   5. Moderately unhealthy
   6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
   1. Very little stress
   2. Some stress
   3. Quite a bit of stress
   4. A moderate amount of stress
   5. A great deal of stress
   6. Unbearable amounts of stress
4. How optimistic are you about the future?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
4. I have a lot of say about what happens in my treatment.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total: _____

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

APPENDIX C

Table 1
Percent of Youths Receiving Each CWD-A Step

Step	Percent
Step 1 – Depression and Social Learning	80.6%
Step 2 – Self-Observation and Change	51.0%
Step 3 – Reducing Tension	30.2%
Step 4 – Learning How to Change	22.6%
Step 5 – Changing your Thinking	17.7%
Step 6 – The Power of Positive Thinking	12.2%
Step 7 – Disputing Traditional Thinking	5.9%
Step 8 – Relaxation	4.2%
Step 9 – Communication, Part 1	2.1%
Step 10 – Communication, Part 2	1.0%
Step 11 – Negotiation and Problem Solving, Part 1	3.5%
Step 12 – Negotiation and Problem Solving, Part 2	0.7%
Step 13 – Negotiation and Problem Solving, Part 3	0%
Step 14 – Negotiation and Problem Solving, Part 4	0%
Step 15 – Life Goals	1.0%
Step 16 – Prevention, Planning, and Ending	1.0%

Note: Length of CWD-A treatment ranged from 1-28 sessions ($M = 5.26$, $SD = 4.70$).

Table 2
Descriptive Statistics of Manual Adaptation

Group	Double-Dips		Skips		Flips	
	%	M (*SD*)	%	M (*SD*)	%	M (*SD*)
Therapists	92.1	N/A	55.3	N/A	43.2	N/A
All youths	69.4	2.92 (*3.67*) [a]	29.5	.88 (*2.29*) [b]	20.9	.26 (*.56*) [c]
Youths Receiving Adaptation	100	4.21 (*3.74*) [a, d]	100	3.00 (*3.40*) [b, e]	100	1.23 (*.56*) [c, f]

[a]Range: 0-22. [b]Range = 0-14. [c]Range: 0-3. [d]Mean number of double-dips, only for youths who received them. [e]Mean number of skips, only for youths who received them. [f]Mean number of flips, only for youths who received them.

Table 3
Correlations Among Study Variables

		Y Age	Y Gender[a]	T-Y Gender Match	Y African-American[b]	Y Hispanic[b]	Y Asian[b]	T-Y Ethnic Match	Y Annual Family Income	Y Pre-Treatment Ohio PS[c]	Y Pre-Treatment Ohio F[d]	Y Number of Diagnoses	T Age	T Gender[a]	T African-American[b]	T Hispanic[b]	T Years Employmt MHMR	Ohio PS Change, Double-dips & Flips[e]	Ohio PS Change, Skips[f]	Ohio F Change, Double-dips & Flips[e]	Ohio F Change, Skips[f]	Double-dips[g]	Skips[g]	Flips[g]	Number CWD-A Sessions[g]
Y Age	*r*	1.000																							
	n	288																							
Y Gender[a]	*r*	.053	1.000																						
	n	288	288																						
T-Y Gender Match	*r*	-.032	-.796**	1.000																					
	n	278	278	278																					
Y African-American[b]	*r*	-.011	.115	-.048	1.000																				
	n	288	288	278	288																				
Y Hispanic[b]	*r*	.023	-.028	.001	-.582**	1.000																			
	n	288	288	278	288	288																			
Y Asian[b]	*r*	-.036	-.090	.065	-.134*	-.256**	1.000																		
	n	288	288	278	288	288	288																		
T-Y Ethnic Match	*r*	-.034	-.081	.056	.159**	-.186**	-.187**	1.000																	
	n	278	278	278	278	278	278	278																	
Y Annual Family Income	*r*	.021	.030	-.011	-.108	.069	-.011	.052	1.000																
	n	226	226	218	226	226	226	218	226																
Y Pre-Treatment Ohio PS[c]	*r*	-.129*	-.002	.057	-.017	.073	-.179**	.106	-.108	1.000															
	n	242	242	233	242	242	242	233	189	242															
Y Pre-Treatment Ohio F[d]	*r*	.143*	-.078	.031	-.020	.003	.130*	-.042	-.069	-.498**	1.000														
	n	242	242	233	242	242	242	233	189	242	242														
Y Number Diagnoses	*r*	-.055	.164**	-.112	.091	-.056	-.063	.097	.038	.022	-.018	1.000													
	n	286	286	276	286	286	286	276	225	240	240	286													
T Age	*r*	.107	.006	.061	.036	-.102	-.074	-.071	.112	-.092	-.118	-.174**	1.000												
	n	278	278	278	278	278	278	278	218	233	233	276	278												
T Gender[a]	*r*	.109	.058	-.015	.038	-.043	-.031	-.079	-.012	-.057	.041	.053	.416**	1.000											
	n	278	278	278	278	278	278	278	218	233	233	276	278	278											
T African-American[b]	*r*	-.159**	.017	-.027	.205**	-.079	-.074	-.001	-.191**	.002	.141*	.118	-.441**	-.183**	1.000										
	n	278	278	278	278	278	278	278	218	233	233	276	278	278	278										
T Hispanic[b]	*r*	.046	-.085	.077	-.136*	.142*	.127*	.332**	.124	.042	-.081	.094	-.273**	-.122*	-.374**	1.000									
	n	278	278	278	278	278	278	278	218	233	233	276	278	278	278	278									
T Years Employmt MHMR	*r*	.061	.087	-.095	-.026	.122*	-.029	.077	.125	.031	-.142*	-.019	.008	-.180**	-.297**	.368**	1.000								
	n	278	278	278	278	278	278	278	218	233	233	276	278	278	278	278	278								
Ohio PS Change, Double-dips & Flips[e]	*r*	.051	-.003	-.143*	-.086	.008	.227**	.004	.212**	-.682**	.375**	.159*	.003	.170*	-.283**	.311**	.193**	1.000							
	n	209	209	203	209	209	209	203	168	187	187	208	203	203	203	203	203	209							
Ohio PS Change, Skips[f]	*r*	.056	.020	-.113	-.039	.005	.176**	-.058	.179**	-.763**	.401**	.135*	.030	.170**	-.209**	.137*	.115	.988**	1.000						
	n	266	266	257	266	266	266	257	207	242	242	264	257	257	257	257	257	209	266						
Ohio F Change, Double-dips and Flips[e]	*r*	.012	.106	-.016	.136*	-.178*	-.144*	-.218**	-.117	.232**	-.489**	-.191**	.512**	.019	.036	-.632**	-.328**	-.495**	-.424**	1.000					
	n	209	209	203	209	209	209	203	168	187	187	208	203	203	203	203	203	209	209	209					
Ohio F Change, Skips[f]	*r*	-.071	.146*	-.059	.129*	-.143*	-.180**	-.124*	-.105	.372**	-.653**	-.045	.298**	.059	.153*	-.464**	-.251**	-.512**	-.460**	.821**	1.000				
	n	266	266	257	266	266	266	257	207	242	242	264	257	257	257	257	257	209	266	209	266				
Double-Dips[g]	*r*	.024	.037	-.089	-.089	.085	-.086	.059	.004	-.013	.036	-.003	.073	.086	-.001	-.004	.146*	.121	.100	-.046	.025	1.000			
	n	288	288	278	288	288	288	278	226	242	242	286	278	278	278	278	278	209	266	209	266	288			
Skips[g]	*r*	.036	-.014	-.012	.060	-.047	-.067	.045	.033	.138*	-.021	-.108	.115	.048	.024	-.027	.005	-.161*	-.160**	.149*	.144*	.061	1.000		
	n	288	288	278	288	288	288	278	226	242	242	286	278	278	278	278	278	209	266	209	266	288	288		
Flips[g]	*r*	-.111	.104	-.100	.109	.002	-.123	.011	-.056	.094	.028	-.007	.079	-.036	.164*	-.179**	.022	-.007	-.002	.070	.097	.299**	.163*	1.000	
	n	225	225	218	225	225	225	218	182	187	187	224	218	218	218	218	218	209	209	209	209	225	225	225	
Number CWD-A Sessions[g]	*r*	.033	.032	-.093	-.043	.050	-.101	.024	-.012	.023	.062	.015	.054	.134*	.070	-.112	.040	.070	.068	.009	.082	.922**	.073	.413**	1.000
	n	288	288	278	288	288	288	278	226	242	242	286	278	278	278	278	278	209	266	209	266	288	288	225	288

[a]Females coded "0". [b]Relative to Caucasians. [c]Pre-Treatment Symptom Severity. [d]Pre-Treatment Functioning. [e]Change in Symptom Severity/Functioning for Youths with Double-Dips or Flips data.
[f]Change in Symptom Severity/Functioning for Youths with Skips data. [g]Number of Double-Dips/Skips/Flips per Youth. [h]Total Number of CWD-A Sessions per Youth.
* $p < .05$. ** $p < .01$.

Table 4
Normality Statistics for Manual Adaptation Variables

Variable	Skewness M (*SD*)	Kurtosis M (*SD*)
Double-Dips[a]	2.00 (*.14*)	5.06 (*.29*)
Skips[a]	3.59 (*.14*)	13.17 (*.29*)
Flips[b]	2.55 (*.16*)	7.37 (*.32*)

[a]N=288. [b]n=226.

Table 5
Individual Predictors of Manual Adaptation

Predictor	Double-Dips			Skips			Flips		
	B	OR	95% OR CI	B	OR	95% OR CI	B	OR	95% OR CI
Youth									
Age	-0.005	0.995	(0.963, 1.029)	-0.044	0.957	(0.900, 1.018)	-0.077	0.926	(0.785, 1.091)
Gender[a]	0.024	1.024	(0.937, 1.119)	-0.214	0.808	(0.615, 1.060)	0.368	1.444	(0.833, 2.504)
Therapist-Youth Gender Match	-0.022	0.978	(0.894, 1.070)	0.301	1.351	(0.968, 1.886)	-0.369	0.692	(0.402, 1.189)
African-American[b]	-0.097	0.908	(0.760, 1.085)	-0.559**	0.572	(0.439, 0.745)	0.597	1.816	(0.752, 4.387)
Hispanic[b]	-0.009	0.991	(0.887, 1.108)	-0.561**	0.571	(0.467, 0.696)	0.315	1.371	(0.617, 3.047)
Asian[b]	-0.054	0.947	(0.823, 1.089)	-0.984**	0.374	(0.241, 0.581)	-32.383	0.000	(0.000, 1.000)
Therapist-Youth Ethnic Match	0.032	1.033	(0.926, 1.152)	0.363*	1.438	(1.005, 2.058)	0.146	1.158	(0.835, 1.605)
Family Income	-0.010	0.990	(0.951, 1.030)	0.029**	1.344	(1.290, 1.401)	-0.090	0.914	(0.790, 1.057)
Pre-Treatment Symptom Severity	-0.038	0.963	(0.904, 1.025)	0.282**	1.325	(1.117, 1.573)	0.122	1.130	(0.952, 1.340)
Pre-Treatment Functioning	-0.003	0.997	(0.928, 1.072)	-0.166	0.847	(0.751, 1.002)	0.037	1.037	(0.865, 1.244)
Number of Diagnoses	0.009	1.009	(0.956, 1.064)	-0.014	0.986	(0.907, 1.071)	-0.096	0.909	(0.725, 1.139)
Therapist									
MHMR Years of Employment	0.016*	1.016	(1.003, 1.029)	-0.030	0.970	(0.936, 1.006)	0.017	1.017	(0.982, 1.053)
Gender[a]	0.142	1.153	(0.901, 1.475)	0.676	1.966	(0.127, 30.553)	-0.672**	0.511	(0.263, 0.993)
Age	0.007	1.007	(0.993, 1.021)	-0.022	0.978	(0.928, 1.031)	0.017	1.017	(0.969, 1.068)
African-American[b]	-0.116	0.891	(0.687, 1.155)	-0.073	0.930	(0.387, 2.237)	0.433	1.542	(0.625, 3.800)
Hispanic[b]	0.149	1.161	(0.860, 1.567)	1.161	3.193	(0.546, 18.671)	-1.388**	0.250	(0.095, 0.654)

[a]Females coded "0". [b]Relative to Caucasians. * $p < .05$. ** $p < .01$.

Table 6
Hierarchical Linear Regressions Predicting Skips from Significant Youth Predictors

Predictor	*B*	OR	95% CI for OR	*p*
Pre-Treatment Symptom Severity				
Intercept	-1.168	0.311	(0.135, 0.716)	.008**
Pre-Treatment Symptom Severity	0.282	1.325	(1.117, 1.573)	.002**
Annual Family Income				
Intercept	-0.732	0.481	(0.161, 1.438)	.184
Annual Family Income	0.296	1.344	(1.290, 1.401)	.000**
Therapist-Youth Ethnic Match				
Intercept	-1.344	0.261	(0.150, 0.453)	.000**
Therapist-Youth Ethnic Match	0.363	1.438	(1.005, 2.058)	.047*
Ethnicity[a]				
Intercept	-0.371	0.670	(0.308, 1.544)	.036*
African-American	-0.559	0.572	(0.439, 0.745)	.000**
Hispanic	-0.561	0.571	(0.467, 0.696)	.000**
Asian	-0.984	0.374	(0.241, 0.581)	.000**

Note. OR = Odds Ratio, CI = Confidence Interval. All models were over-dispersed.
[a]Relative to Caucasians.
* $p < .05$. ** $p < .01$.

Table 7
Full Model Hierarchical Linear Regression Predicting Skips from Significant Youth Predictors

Predictor	*B*	OR	95% CI for OR	*p*
Intercept	-1.060	0.346	(0.127, 0.943)	.039*
Annual Family Income	0.371	1.449	(1.317, 1.593)	.000**
Pre-Treatment Symptom Severity	0.255	1.290	(1.112, 1.496)	.001**
Therapist-Youth Ethnic Match	0.279	1.322	(0.957, 1.826)	.090
Ethnicity[a]				
African-American	-0.362	0.696	(0.422, 1.027)	.068
Hispanic	-0.390	0.677	(0.505, 0.908)	.010**
Asian	-0.643	0.526	(0.422, 0.655)	.000**

Note. OR = Odds Ratio, CI = Confidence Interval. Model was over-dispersed.
[a]Relative to Caucasians.
* $p < .05$. ** $p < .01$.

Table 8

Hierarchical Linear Regressions Predicting Manual Adaptation from Significant Therapist Predictors

Predictor	*B*	OR	95% CI for OR	*p*
Double-dips				
Intercept	-.736	0.479	(0.404, 0.568)	.000**
Years Employed at MHMR	0.109	1.115	(1.019, 1.219)	.019*
Flips				
Intercept	-3.031	.048	(0.030, 0.076)	.000**
Sex[a]	-0.672	.511	(0.263, 0.993)	.048*
Flips				
Intercept	-3.173	0.042	(0.020, 0.089)	.000**
African-American	0.433	1.542	(0.625, 3.800)	.336
Hispanic	-1.388	0.250	(0.095, 0.654)	.007**

Note. OR = Odds Ratio, CI = Confidence Interval. All models were under-dispersed.
[a]Females coded "0".
* $p < .05$. ** $p < .01$.

Table 9

Full Model Hierarchical Linear Regression Predicting Flips from Significant Therapist Predictors

Predictor	*B*	OR	95% CI for OR	*p*
Intercept	-3.005	0.050	(0.021, 0.116)	.000**
Sex[a]	-0.685	0.504	(0.217, 1.172)	.108
African-American	0.303	1.354	(0.518, 3.535)	.524
Hispanic	-1.516	0.220	(0.081, 0.592)	.005**

Note. OR = Odds Ratio, CI = Confidence Interval. Model was under-dispersed.
[a]Females coded "0".
* $p < .05$. ** $p < .01$.

Table 10
Hierarchical Linear Regressions Predicting Outcomes from Adaptation

Predictor	Ohio PS		Ohio F	
	B	*p*	*B*	*p*
Double-dips				
Intercept	-.267	.000**	.111	.000**
Total Number of CWD-A Sessions	-.005	.006**	-.000	.847
Pre-Treatment Symptom Severity	-.009	.000**	N/A	N/A
Pre-Treatment Functioning	N/A	N/A	-.002	.000**
Double-dips	.007	.003**	.000	.904
Skips				
Intercept	-.277	.000**	.113	.000**
Total Number of CWD-A Sessions	.000	.771	.000	.433
Pre-Treatment Symptom Severity	-.012	.000**	N/A	N/A
Pre-Treatment Functioning	N/A	N/A	-.004	.000**
Skips	-.003	.035*	.001	.176
Flips				
Intercept	-.268	.000**	0.111	0.000**
Total Number of CWD-A Sessions	-.001	.404	0.000	0.711
Pre-Treatment Symptom Severity	-.009	.000**	N/A	N/A
Pre-Treatment Functioning	N/A	N/A	-0.002	0.000**
Flips	.005	.410	-0.003	0.050*

*$p < .05$. ** $p < 01$.

VITA

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